FEDERAL HEALTH BENEFITS REFORM ACT OF 1983

HR 656

proposed by Ms. Oakar

HR 656 submitted by Ms. Oakar is a fairly comprehensive bill which seeks to build on the existing FEHBP program by strengthening individual health insurance coverage areas, increasing the government share of premiums, and allowing participation by some people now excluded from FEHBP.

Specifically, the legislation would:

* Increase the government share of health insurance premiums by raising it from 60% to 75% of the "Big Six" average with the maximum contribution to any plan increasing from 75% to 100%.

* Provide 5% of average subscription charge as government differential for retirees and employees 65 or older who are not eligible for medicare.

* Permit continuing participation in the FEHBP up to twelve months for employees separated from service due to reductions-in-force and indefinitely for dependents (spouses and qualifying children) of employees or retirees whose marriages are dissolved provided that the employee or retiree was enrolled in an approved health benefits plan prior to the separation or divorce.

* Establish minimum mental and nervous (M&N) benefits of 50 outpatient visits, 60 days inpatient, and two 28 day periods for alcoholism treatment and rehabilitation.

* Provide that limitations on M&N may be exceeded on a case by case basis if "peer review mechanism" determines the treatment to be necessary.

* Provide catastrophic protection for M&N costs that would pay 80% of outpatient visits over 50 and 80% of inpatient care in excess of 60 days.

* Create a fund for catastrophic M&N expenses by allocating a percentage of premiums.

* Add "comprehensive dental benefits" to the types of benefits which may be provided by plans within FEHBP.

The bill would impact on the Agency by:

* Requiring the utilization of an established "peer review mechanism" when exceeding limited M&N benefits on a case by case basis.

* Adding dental coverage.

* Increasing the government contribution resulting in less out-of-pocket cost for premiums.

* Causing premiums of most other plans to increase at a higher rate than ABP since mental and nervous benefits within ABP already exceed the proposed minimum levels while many other plans would have to catch up.

Recommendation:

The Agency should actively support the Oakar bill. We view every change the bill seeks to institute as positive. By improving coverage in some areas the bill could increase costs but this is offset by increasing the government share of premiums.

We do have some cover and security concerns about the requirement that a "peer review mechanism" approve M&N benefits in excess of normal limitations. Also, the bill would initiate a fund for catastrophic M&N expenses but doesn't specify the method of payment (i.e. direct to provider of service, direct to policyholder, to carrier, to underwriter?) which could present the Agency with administrative worries. Nonetheless, the bill is positive and would legislate many worthwhile changes for federal employees without sacrificing the structure and good elements of the existing FEHBP.

FEDERAL EMPLOYEES HEALTH BENEFITS REFORM ACT OF 1983

HR 3798

by Mr. Dannemeyer

This legislation proposes sweeping changes to the current FEHBP system. It would revise the system entirely resulting in new forms, new methods of determining the government contribution, liberalized guidelines determining which plans could participate and would relieve OPM of the responsibility to negotiate rates and benefits.

Specifically, HR 3798 would:

* Base government contribution on the average of all plans within FEHBP (vice Big Six) and adjust annually according to GNP deflator as well as deleting the 75% maximum limit on government contribution to any plan.

* Replace the Health Benefits Registration Form (2809) with a "voucher" on which employees would enroll or change enrollment within FEHBP.

* Promote greater competition by allowing any state licensed plan to participate.

* Specify minimum catastrophic coverage for all plans.

The bill would impact on the Agency by:

* Causing employees to pay a much greater portion of health insurance premiums which could severely affect those "captive" policyholders not able to take advantage of larger plan selection.

* Encouraging employees to select less expensive low option plans thereby increasing the risk of large financial burden if serious illness or injury occurred.

* Increasing administrative difficulties in coordinating enrollments and coverage among the many FEHBP participating plans.

Recommendation:

We agree with the sponsor that under the voucher plan "choice would be greater, the cost more predictable, and the cost reducing incentives more effective" but none of these are likely to be beneficial for federal employees. We recommend that the Agency studiously avoid giving any indication that the bill would be received positively. At the same time we can find no concrete security or administrative basis on which to seek an Agency exception.

ROUTING AND RECORD SHEET

SUBJECT: (Optional)

25X1
FROM: [redacted]
Deputy Chief, Insurance Branch
915 Ames Building

25X1

EXTENSION: [redacted]

NO.

DATE: 6 October 1983

TO: (Officer designation, room number, and building)	DATE RECEIVED	DATE FORWARDED	OFFICER'S INITIALS	COMMENTS (Number each comment to show from whom to whom. Draw a line across column after each comment.)
1. C/BSD	10/12		[illegible] Bill	Attached are brief discussions concerning three legislative proposals relative to the Federal Employees Health Benefits Program. Oakar's bill would be most advantageous to Agency employees, Durenberger's bill would be reasonable for us and Dannemeyer's bill would be negative with few if any advantages and several disadvantages.
2. DC/BSD	10/12/83		[illegible]	
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ROUTING AND TRANSMITTAL SLIP

Date
15 Sept 1983

TO: (Name, office symbol, room number, building, Agency/Post)	Initials	Date
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FEDERAL PERSONNEL GUIDE

WEEKLY NEWS UPDATE©

VOLUME I, No. 35 Washington, D.C. SEPTEMBER 5, 1983

ADMINISTRATION ANNOUNCES PAY INCREASE

President Reagan late last Wednesday recommended that federal employees receive only a 3.5 percent pay increase, not to become effective until the first pay period in January.

Because the Supreme Court struck down so called "legislative vetoes", the President's action will become effective unless Congress passes a completely separate piece of legislation directing a different pay raise. White House sources "fully expect that Congress will do just that", and overrule the President.

In fact, some source say that the White House not only expects, but hopes Congress passes just such a law and avoids the whole question of the President's authority to delay the raise.

In 1972, the National Treasury Employees Union successfully challenged a pay raise delay imposed on federal workers by President Nixon. Government employees won a total of $533 million in back pay in 1974 as a result of that challenge. However, the White House spokesman said that that suit was lost because Nixon used the wrong law. Nixon used wage and price controls authority in effect at that time, but the authority did not extend to federal workers.

A White House source indicated that the President would find it very difficult to veto pay raise legislation, especially if it includes relief for new federal employees who have to pay social security and the civil service retirement contributions, and the expected delay in cost-of-living adjustments for civil service retirees.

The 3.5 percent pay raise was apparently decided upon because it is identical to what social security annuitants will also be getting on January 1.

(See following stories for details which were filed prior to the President's announcement.)

WOULD OPM REFORMS HELP?

An OPM study shows that white collar civil servants in the lowest and highest non-executive grades would have gotten higher pay raises under reforms pushed by OPM than the four percent now likely to be granted all grades.

However, the average pay raise for *all* grades would have been slightly less than four percent, and some grades would have gotten less than one percent.

Under present law, white collar pay is supposed to be based on an annual survey of private sector pay (called the "National Survey of Professional, Administrative, Technical and Clerical Pay," or "PATC") conducted by the Bureau of Labor Statistics. This year's survey show General Schedule employees to be an average of 21.51 percent behind their counterparts in the private sector.

But the survey's results have been ignored every year since 1976, and nine out of the last 11 years. Instead, presidents have offered "alternative pay plans," much less than the amount called for in the PATC survey. One of the reasons is that a succession of presidents have questioned the PATC survey's reliability.

Although the President called for a total pay freeze in his budget message to the Congress last January, he has not yet offered an alternative plan for this year's raise. As we went to press, at least one Senate aide said that he expected the President to come up with a meager 3.45 percent pay increase — instead of the four percent all hands seem to be taking for granted.

Although that *rumor* has not been nailed down, it does show the skittishness on the Hill over the pay raise question. Since the Supreme Court knocked out the power of Congress to overrule a presidential pay plan by a simple majority vote in either house, it will be tougher for Congress to buck a president determined to keep the pay raise down.

In any case, it is wildly unlikely that any president is going to accept the pay gap shown in the PATC surveys. Last December, OPM floated a number of ways in which it said the survey could be made more acceptable.

Those suggestions got the deep freeze from federal unions, and no changes have been made in the survey yet. But OPM made up a hypothetical pay scale, based on what the rates would have been if changes which did not require legislation had been made in the survey.

The results were that employees in grade GS-1 and GS-3 would have gotten raises of over 5 percent. Employees in grades GS-13 through GS-15 would have gotten pay hikes of slightly more than 6, 9 and 13 percent, respectively.

OPM officials claim that the results prove their argument that if civil servants put pay reform behind them, they could start enjoying pay raises better than those they are likely to get under the "alternative pay plans."

DEFENSE RAISE

House and Senate conferees signaled the likely timing of civilian employees' pay raise last month in approving a

(Continued on next page)

$187.5 billion authorization bill for the Department of Defense. ("Authorization" bills set how much money a government program or agency can legally spend, and what it can spend it on; "appropriations" bills allow the Treasury to actually spend the funds, or "put the money in the bank.")

The authorization bill allows a four percent pay hike for civilian employees (and military personnel, except recruits in their first four months of service) to take effect on January 1, 1984.

Both House and Senate committees had planned for the raise to take effect on April 1. But noting that Congress is aiming for a January 1 date for the increase, the conferees tossed an extra $244 million in the pot to cover pay raises for DOD employees.

PAY CUT CLARIFICATION

We knew it at the time. We just goofed. A gremlin slipped in between one of our editors and last week's final copy in our story about the pay cut caused by recomputation of the work year.

We said the most anyone would lose would be $8.80 per year. The fact is, that should have read $8.80 per *pay period*, which is what it said in our copy "B.G." — "before Gremlin."

Our apologies, and we hope not too many office arguments were set off by that mishap.

FULL SCALE RETIREMENT STUDY IN SENATE

A bi-partisan group of four Senators has set in motion a full scale review of federal retirement issues.

The four are all members of the Senate Committee on Governmental Affairs — the parent committee of the Senate Civil Service Subcommittee.

Governmental Affairs Chairman William V. Roth, Jr., R-DE, was joined by Senators Ted Stevens, R-AK, Thomas Eagleton, D-MO, and Jeff Bingaman, D-NM, in asking three Congressional support agencies to review the retirement issues.

"The federal pension system and the employees it protects are too important to undertake anything less than a comprehensive study," Roth said. "I want to emphasize that we are not involved in pre-judging or ready-made conclusions. We expect full participation by employees, employee groups, business leaders, and pension experts as the process continues."

The General Accounting Office, Congressional Budget Office, and Congressional Research Service have each been assigned a major part of the study.

FPG WEEKLY NEWS UP•DATE staff obtained an internal committee outline of the study plan, which includes three major facets:

• *Comparison of Public and Private Sector Pension Practice.* The study will collect data "describing the existing retirement system and comparing it with practices in the public and private sector." Included in the study will be issues such as "cost, replacement rates, portability, inflation protection, retirement age, survivor benefits, and disability benefits."

• *Financing and Funding Issues.* The study will include a "thorough description of the way the Civil Service Retirement Trust Fund operates," including a description of the "unfunded liability, its consequences for maintaining a federal retirement program, (and) the impact of the unfunded liability and amortizing it on the national debt."

The study will also look at how private pension plans are funded and examine how the federal pension plan could be funded along the same lines.

• *Policy Rationale for Various Pension Practices.* "The study will define and give consideration to employee and employer goals in the pension program." Various types of pension programs will be studied to see how they meet these various goals.

In short, this key committee is aiming at giving the patient the most thorough physical examination it has had in years, and seems to be serious about coming up with a major reform. Whether it can pull off the trick of getting enough political support from enough players remains to be seen.

Staffers deny that the study by the full committee indicates any unhappiness with the way Senator Stevens' subcommittee was dealing with the issue.

One thing is certain, though. With the present system split between new employees covered by both Social Security and CSR, and old employees only under CSR, something has to give. There will be change.

NEW HIRE RELIEF PLANNED

The Senate civil service subcommittee plans to hold hearings on September 14 to decide what to do about federal workers hired after the first of the year. Those workers will be covered both by the civil service retirement system and the Social Security system, and thus subject to withholding for both.

The subcommittee has asked GAO to come up with an interim solution to give the new workers some relief, and plans to attach it to an early bill right after the current recess ends on September 12.

HERE'S TO YOUR HEALTH (BENEFITS)

Three different programs to reform the Federal Employees Health Benefits Program have been offered in the Congress and await action when the Congress returns.

The administration's "voucher plan" has been formally offered in Congress by Rep. William E. Dannemeyer, R-CA.

In offering the bill, Dannemeyer said "choice could be greater, the cost more predictable, and the cost-reducing incentives more effective" under the voucher plan than the current system.

The essence of the voucher plan is the payment to all federal workers of a flat rate, which they can then use to purchase their own insurance from any state-licensed plan which met federal financial soundness criteria. Employees who need "Cadillac" coverage would pay the higher premiums themselves, while employees who select more modest coverage could pocket the difference.

The Californian urged his colleagues to give the administration plan a fair hearing, although conceding that it "is a good starting point for discussion but not the last word."

However, it is unlikely that the plan will see the light of day in the House Post Office and Civil Service Committee, controlled by Democrats.

Alaskan Republican Sen. Ted Stevens will introduce his health benefits reform bill right after the recess also. Details aren't known yet, but the bill has three main features:

- Annuitants would have their own special health benefits plans, and the government would contribute more to the insurance carriers enrolling the most annuitants.
- The government contribution would be increased over all plans.
- A number of "cost containment" features will be built into the law to cut down on overall costs.

So far the most supported legislation is that offered by Rep. Mary Rose Oakar, D-OH. The major features of Oakar's bill, on which extensive hearing have already been held, are:

- Restricts OPM's authority to delay or cancel open season, or reduce benefits unilaterally.
- Increases government's contribution rate from 60 percent of average charge of "Big Six" plans to 75 percent. It also allows that contribution to be applied to 100 percent of any given plan's costs (i.e., if the plan's premium is equal to or less than 75 percent of the "Big Six" average.) Government also will pay 5 percent differential to a health plan that enrolls a non-Medicare eligible over 65 years of age.
- Provides dental coverage government wide.
- Standardizes mental health benefit level at 50 outpatient visits and 60 in-patient visits.
- Requires all plans to accept annuitants.
- Permits separated employees to continue their enrollment in health plan, provided that they pay the entire health premium.

HARD TO DIGEST?

Some federal employees may find September's Reader's Digest hard to digest. The magazine — which has a circulation of over 18 million — features an article entitled "Uncle Sam's Out-of-Control Pension Program." FPG WEEKLY NEWS UP•DATE editors obtained an advance copy of the article, which is on its way to homes and newsstands now.

Theme of the article: "There's a massive gap — $515 billion — between what the Civil Service Retirement System promises to pay in future benefits and the money it will have available. Congress must act *now* to reform the system." The magazine also criticizes "lucrative military pensions" in an aside.

The article calls for reforms of the CSRS along the lines of those proposed by the Reagan administration (See February 7, 1983 FPG WEEKLY NEWS UP•DATE for details) or the plan offered during the last Congress by Sen. Ted Stevens, R-AK (See January 10, 1983 FPG WEEKLY NEWS UP•DATE).

Because the article is one the Digest offers for reprint, it is expected to get wide circulation beyond the magazine's subscribers.

Also worth noting is the August 22 edition of U.S. News & World Report, which features an article titled "Now, Government Pensions in Trouble, Too."

That article concludes, "To an administration and Congress scrambling to dry up federal red ink, benefits like those in federal retirement programs are becoming a bigger and bigger target."

IS A MOVE UP A MOVE DOWN?

Dreaming of making a move to another part of the country? You ought to consider the following table of comparative average housing costs, published last month by the Mail Handlers Union. The union points out that a move from one location to another can result in a big loss in housing costs.

City	Home Price	City	Home Price
Albuquerque, NM	$88,550	Memphis, TN	$81,000
Atlanta, GA	95,000	Miami, FL	128,500
Billings, MT	115,000	New Orleans, LA	88,500
Boise, ID	80,000	New York, NY	
Boston, MA	95,000	NY Suburban	166,000
Buffalo, NY	58,000	CT Suburban	120,000
Cheyenne, WY	86,500	L.I. Suburban	104,000
Cincinnati, OH	79,000	Oklahoma City, OK	90,000
Columbia, SC	73,500	Philadelphia, PA	76,000
Dallas, TX	183,000	Phoenix, AZ	82,500
Denver, CO	95,000	Pittsburgh, PA	86,000
Detroit, MI	81,500	Portland, OR	120,000
Honolulu, HI	199,000	St. Louis, MO	110,000
Jackson, MS	80,500	St. Paul, MN	127,000
Los Angeles County, CA		Salt Lake City, UT	80,000
San Fernando Val.	175,000	Seattle, WA	115,000
San Gabriel Val.	150,000		
Westside	325,000		
South Bay	250,000		

The Mail Handlers did not include Washington, DC in the chart, but average home prices in Washington have run well over $100,000 in recent months.

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FEDERAL PERSONNEL GUIDE
and
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Dear Federal Employee:

This sample copy of the FEDERAL PERSONNEL GUIDE WEEKLY NEWS UP•DATE, is provided, with our compliments, to introduce you to the newest weekly newsletter specifically prepared for federal employees. Now, at last, there is a weekly compilation of the most current, up-to-date news of interest and importance for all federal workers... four pages of news from the White House, the Congress, the Office of Personnel Management, other federal agencies, boards, unions and the courts.

The expanded Federal Personnel Publications staff, will be covering the newsmakers and will bring the most current, vital news as well as commentary and analysis to FPG WEEKLY NEWS UP•DATE readers on a regular basis and will complement the basic information contained in the annual FEDERAL PERSONNEL GUIDE.

Although this copy of the FPG WEEKLY NEWS UP•DATE may be dated by the time you read it, regular subscribers will be getting their copies on a timely basis week after week, thus enabling them to keep up with the constant changes emanating from the seat of government. Now, all federal employees will have the opportunity to stay abreast of the latest events which will impact directly on their jobs and their futures. Issues such as pay and retirement reform, health benefits, inclusion in Social Security and so many others, will be reported as the Congress and the Administration deliberate and act. The FPG WEEKLY NEWS UP•DATE will provide you with up-to-date news as it is developed in Washington.

Until December 31, 1983, new subscribers can take advantage of our special first year subscriber offer which will bring the FPG WEEKLY NEWS UP•DATE to your home or office for only $18.00 per year. And, if you subscribe for two years, you pay only $33.00. At these low introductory prices (36¢ a week or less) you can hardly go wrong.

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After you have placed your order, please pass this letter around to your colleagues. They will also like to take advantage of this money saving opportunity and can use the enclosed order forms or a facsimile to order their personal subscription to the FPG WEEKLY NEWS UP•DATE and/or additional copies of the 1983 FEDERAL PERSONNEL GUIDE. Don't let this unique money saving offer get away from you or your fellow employees.

Sincerely yours,

Lee E. Sharff

LEE E. SHARFF
Publisher

ROUTING AND RECORD SHEET

SUBJECT: (Optional)

STAT

FROM: [redacted]

Deputy Director of Personnel
for Special Programs
5E-56 Headquarters

STAT

EXTENSION: [redacted]

NO.

DATE: AUG 19 1983

TO: (Officer designation, room number, and building)	DATE RECEIVED	DATE FORWARDED	OFFICER'S INITIALS	COMMENTS (Number each comment to show from whom to whom. Draw a line across column after each comment.)
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FORM 1-79 610 USE PREVIOUS EDITIONS

98TH CONGRESS
1ST SESSION

H. R. 3798

To restructure the Federal employees health benefits program to strengthen financial control over the program and enhance competition among participating health benefits plans, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

AUGUST 4, 1983

Mr. DANNEMEYER (by request) introduced the following bill; which was referred to the Committee on Post Office and Civil Service

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A BILL

To restructure the Federal employees health benefits program to strengthen financial control over the program and enhance competition among participating health benefits plans, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Federal Employees Health Benefits Reform Act of 1983".

SEC. 2. (a) Chapter 89 of title 5, United States Code, is amended to read as follows:

"CHAPTER 89—EMPLOYEE HEALTH INSURANCE

"§ 8901. Definitions

"For purposes of this chapter—

"(1) 'employee' means—

"(A) an employee as defined by section 2105 of this title;

"(B) a Member of Congress as defined by section 2106 of this title;

"(C) a Congressional employee as defined by section 2107 of this title;

"(D) the President;

"(E) an individual employed by the government of the District of Columbia, unless otherwise provided by the District of Columbia Council in accordance with section 714(c) of the Act of December 24, 1973 (87 Stat. 819);

"(F) an officer or employee of the United States Postal Service, unless otherwise provided by the Postal Service in accordance with section 1005(f) of title 39;

"(G) an individual employed by Gallaudet College;

"(H) an individual employed by a county committee established under section 590h(b) of title 16; and

"(I) an individual appointed to a position on the office staff of a former President under subsection (b) of the first section of the Act of August 25, 1958 (72 Stat. 838);

but does not include—

"(i) an employee of a corporation supervised by the Farm Credit Administration if private interests elect or appoint a member of the board of directors;

"(ii) an individual who is not a citizen or national of the United States and whose permanent duty station is outside the United States, unless the individual was an employee for the purpose of this chapter on September 30, 1979, by reason of service in an Executive agency, the United States Postal Service, or the Smithsonian Institution in the area which was then known as the Canal Zone;

"(iii) an employee of the Tennessee Valley Authority; or "(iv) an employee excluded by regulation of the Office of Personnel Management under section 8909(b) of this title;

"(2) 'Government' means the Government of the United States and the government of the District of Columbia;

"(3) 'annuitant' means—

"(A) an employee who retires on an immediate annuity under subchapter III of chapter 83 of this title or another retirement system for employees of the Government, after 5 or more years of service or for disability;

"(B) a family member who receives an immediate annuity as the survivor of an employee or of a retired employee described by subparagraph (A) of this paragraph;

"(C) an employee who receives monthly compensation under subchapter I of chapter 81 of this title and who is determined by the Secretary of Labor to be unable to return to duty; and

"(D) a family member who receives monthly compensation under subchapter I of chapter 81 of this title as the surviving beneficiary of—

"(i) an employee who died as a result of injury or illness compensable under that subchapter; or

"(ii) a former employee who died while receiving monthly compensation under that subchapter and who had been held by the Secretary to have been unable to return to duty;

"(4) 'service', as used in paragraph (3) of this section, means service which is creditable under subchapter III of chapter 83 of this title;

"(5) 'family member' means the spouse of an employee or annuitant and an unmarried dependent child under 22 years of age, including—

"(A) an adopted child or recognized natural child; and

"(B) a stepchild or foster child, but only if the child lives with the employee or annuitant in a regular parent-child relationship;

or such an unmarried dependent child regardless of age who is incapable of self-support because of mental or physical disability which existed before age 22;

"(6) 'dependent', in the case of any child, means that the employee or annuitant involved is either living with or contributing to the support of such child, as determined in accordance with such regulations as the Office shall prescribe, or if the employee or annuitant is deceased, the deceased individual lived with or contributed to the support of such child immediately before death;

"(7) 'health benefits plan' or 'health plan' means a group insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or similar group arrangement provided by a carrier for the purpose of providing, paying for, or reimbursing expenses for health services;

"(8) 'carrier' means—

"(A) one or more not-for-profit corporations which are organized and authorized under the laws of a State or the District of Columbia for the primary purpose of operating a service benefit health plan, or plans, under which prepaid hospital, medical, surgical, and related services are provided to plan subscribers pursuant to participation agreements between the corporation and physicians, hospitals, and other providers of health services, or any legal entity which is licensed under the laws of a State or the District of Columbia to issue group health insurance policies providing indemnity benefits to covered individuals for specified health care expenses and which offers a qualified health benefits plan, or plans, under this chapter;

"(B) an employee organization which sponsors and administers, in whole or in substantial part, a health plan available only to individuals, and their family members, who are regular or associate members of the organization, except that if an employee organization elects to offer limited associate memberships for purposes of health plan participation under this chapter, associate memberships shall be offered under uniform terms and conditions to all employees and annuitants eligible to enroll in a qualified health benefits plan under this chapter;

"(C) a qualified health maintenance organization within the meaning of section 1310(d)(1) of the Public Health Service Act (42 U.S.C. 300e–9(d)(1)); and

"(D) any corporation, association, partnership, or other organization under contract with the Office of Personnel Management as of September 30, 1984, to offer a comprehensive medical plan described in section 8903(4) of this title (as then in effect), if such organization continues to offer such plan under this chapter after that date;

"(9) 'employee organization' means an association or other organization of employees or retired employees which is national in scope, or in which membership is open to all employees of a Government agency who are eligible to enroll in a qualified health benefits plan under this chapter;

"(10) 'open enrollment season' means a 30-day period, which shall be designated by the Office of Personnel Management prior to the beginning of any plan year for which changes in premium rates or benefits are approved by the Office under this chapter, during which period any eligible employee who is not enrolled in a qualified health benefits plan described in section 8902 of this title may enroll and any enrolled employee or annuitant may change his enrollment to another plan or benefits option;

"(11) 'health care voucher' means a document for use in enrolling in a health benefits plan, or changing enrollment to another plan or benefits option, under this chapter; and

"(12) 'plan year' means a 12-month period beginning on the first day of October.

"§ 8902. Qualified health benefits plans

"(a) A carrier seeking to offer a health benefits plan under this chapter shall apply to the Office of Personnel Management for approval of such plan in such manner as the Office may by regulation require. The Office shall approve any plan for which an application under the preceding sentence is submitted if—

"(1) the carrier certifies that the rates charged for each level of benefits under the plan shall be consistent with the lowest schedule of rates charged for comparable levels under other group policies of such carrier;

"(2) the carrier certifies that each level of benefits under the plan will provide comprehensive benefits for covered services and supplies provided to an enrollee or eligible family member in any plan year, without any additional expenditure by the enrollee if such enrollee has incurred creditable deductible and coinsurance expenditures in that plan year equal to the maximum enrollee financial participation amount under the plan; such amount—

"(A) shall be specified under the terms of the plan;

"(B) shall not be greater than the maximum permissible enrollee financial participation amount which the Office establishes as appropriate for that category of health plan; and

"(C) shall take into consideration enrollee payments for such services as medical, hospital, and surgical benefits, as the Office determines appropriate;

"(3) the carrier agrees to offer each level of benefits to all eligible enrollees at a uniform premium rate for self-only enrollments, and a uniform premium rate for self-and-family enrollments, for a term of at least one plan year;

"(4) the carrier agrees to operate, or contract for, a health services utilization review system satisfactory to the Office;

"(5) the carrier agrees to accept for enrollment, without regard to race, sex, health status, or age, and in accordance with procedures established pursuant to section 8903 of this title, any employee or annuitant who is eligible to enroll in a qualified health benefits plan under this chapter and, if the employee or annuitant so elects, family members, except that—

"(A) a plan offered by a carrier described in subparagraph (A) of section 8901(8) of this title shall be open only to employees and annuitants who reside in a State (or the District of Columbia) in which the carrier is licensed to do business;

"(B) a plan offered by a carrier described in subparagraph (B) of such section shall be open only to employees and annuitants who, at the time of enrollment, are members or associate members of the sponsoring employee organization; and

"(C) a plan offered by a carrier described in subparagraph (C) or (D) of such section may be limited to employees and annuitants who live or work in the geographic area served by such plan;

"(6) the carrier agrees to provide detailed written statements of the rights and obligations of the plan and of its enrollees (including services and benefits to which enrollees are entitled and any maximums, limitations, and exclusions applicable to such services and benefits) in a format approved by the Office, an enrollee identification card, and a description of procedures for obtaining benefits, to all who enroll in the plan under this chapter;

"(7) the carrier agrees that if, during a plan year, an enrollee changes his enrollment to another health benefits plan under conditions prescribed by this chapter (including applicable regulations issued by the Office), the former health plan will permit such enrollee to terminate enrollment and will not require any premium or other payment after enrollment in the plan is terminated;

"(8) the carrier agrees to offer each employee, annuitant, or family member whose eligibility under this chapter is ended, except by voluntary cancellation of health plan enrollment, a 31-day extension of coverage, during which time such individual shall have the option to convert, without evidence of good health, to a nongroup contract with such carrier; such nongroup contract shall include at least the health benefits provided under the lowest level of benefits offered under the qualified health benefits plan from which the individual's enrollment was terminated; the premium for such nongroup contract shall be consistent with the lowest rates charged by the carrier under comparable nongroup policies; any individual who exercises the conversion option under this paragraph shall pay the full periodic premium charges of the nongroup contract directly to the carrier;

"(9) the carrier furnishes to the Office such evidence as the Office may require that the carrier has obtained adequate reinsurance of its health benefits plan against loss, except that the Office may, upon written application, waive such requirement for reinsurance if the carrier shows that such reinsurance is unnecessary because of the carrier's financial stability and capacity for risk absorption; and

"(10) the carrier agrees to furnish such reports as the Office determines to be necessary to enable the Office to carry out its functions under this chapter, and to permit the Office and representatives of the General Accounting Office to examine such records of the carrier as may be necessary to determine the carrier's financial stability and otherwise carry out the purposes of this chapter.

"(b) Approval of a plan under this chapter may be withdrawn by the Office, after notice of the reasons for withdrawal and opportunity for a hearing for the carrier concerned and without regard to subchapter II of chapter 5 and chapter 7 of this title, if the Office determines that the plan is not in compliance with any provision of this chapter or applicable regulations.

"(c) The provisions of any health benefits plan approved under this chapter which are set forth in a written plan description furnished to enrollees under subsection (a)(6) of this section and which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or regulation issued thereunder, which relates to health insurance or plans, or the format of informational materials, to the extent that such law or regulation is inconsistent with such provisions.

"§ 8903. Enrollment procedures

"(a) Each eligible employee upon entering Government service, shall be issued by the employing agency a list of qualified health benefits plans approved under this chapter (including the applicable premium rates) and a health care voucher, on which such employee may indicate choice of plans, level of benefits (if applicable), and whether his enrollment is for self-only or for self-and-family.

"(b) An annuitant who, at the time of becoming such an annuitant, has been enrolled in a qualified health benefits plan under this chapter—

"(1) as an employee for a period of not less than—

"(A) the 5 years of service immediately before retirement; or

"(B) the full period or periods of service between the last day of the first period in which he was eligible to enroll in a health benefits plan under this chapter (or similar provisions of prior law) and the date on which he becomes an annuitant, if less than 5 years; or

"(2) as a family member of an employee or annuitant;

shall continue to be eligible while an annuitant to be enrolled in a qualified health benefits plan under this chapter so long as such individual remains continuously enrolled in any such plan.

"(c) If an employee or annuitant has a spouse who is also an employee or annuitant, either spouse, but not both, may enroll in a qualified health benefits plan for self-and-family coverage, or each spouse may enroll as an individual. However, an individual may not be enrolled both individually as an employee or annuitant and as a family member of another enrollee.

"(d) Each eligible employee and annuitant shall, at the beginning of each open enrollment season, be issued, by his employing agency or retirement system, such materials as the Office may prescribe for purposes of facilitating a choice among available health benefits plans, including a list of qualified health benefits plans and their respective premium rates, instructions for obtaining benefit brochures from carriers, and a health care voucher to be completed and returned to the individual's employing agency or retirement system indicating his choice of plan, level of benefits, and whether the enrollment is for self-only or self-and-family coverage. The Office shall take such steps as it considers appropriate and feasible to ensure that comparative information on available qualified health benefits plan is available to each eligible employee and annuitant during each open enrollment season. Employees and annuitants who are enrolled in a qualified health benefits plan under this chapter and who do not complete and return the health care voucher to their employing agency or retirement system during the open enrollment season to change their enrollment shall continue to be enrolled in the same health benefits plan or, in the event such plan ceases to participate under this chapter, in a plan which is reasonably similar to the discontinued plan, as determined by the Office.

"(e) An employee or annuitant may, under conditions prescribed by regulations of the Office, be issued a health care voucher for the purpose of changing his coverage, or that of himself and his family members, upon application filed with the employing agency or retirement system within 60 days after a change in family status.

"(f) An employee or annuitant may be issued a health care voucher for use in transferring his enrollment from one qualified health benefits plan to another if the health benefits plan in which such individual is enrolled ceases to participate under this chapter, and at such other times and under such other conditions as the Office may by regulation prescribe.

"(g)(1) Each employing agency or retirement system to which a completed health care voucher is returned by an eligible employee or annuitant under this section shall promptly send a copy of the completed voucher to the carrier selected by the employee or annuitant.

"(2) Each employing agency or retirement system that is responsible for the enrollment of employees or annuitants in qualified health benefits plans under this chapter shall promptly notify the carrier concerned, in a manner to be prescribed by the Office, if an employee or annuitant becomes ineligible for continued coverage under that carrier's plan because the employee or annuitant has elected to transfer his enrollment to another carrier in accordance with the procedures under this section or has separated from the service or otherwise become ineligible for continued coverage.

"(3) Each employing agency or retirement system that is responsible for the enrollment of employees or annuitants in qualified health benefits plans under this chapter shall, at the beginning of each calendar year and in a manner to be prescribed by the Office, transmit to each carrier a list of all employees or annuitants for whom the employing agency or retirement system is responsible and who are enrolled in the carrier's plan, together with an identification of the level of benefits under which the employee or annuitant is covered and whether the coverage is for self-only or self-and-family.

"§ 8904. Government contributions and enrollee premiums

"(a)(1) The Office of Personnel Management shall determine before the start of each plan year the basic rates of

Government contributions under this chapter toward the premium charges for self-only and self-and-family enrollments, respectively, in qualified health benefits plans, in accordance with the provisions of this subsection.

"(2) For purposes of determining the Government contribution rates per enrollee for a plan year, the Office shall first determine for the fiscal year preceding such plan year the average biweekly Government contribution made toward self-only and self-and-family health plan enrollments under this chapter, respectively, on behalf of enrollees other than active and retired officers and employees of the United States Postal Service and the survivors of such individuals, including in such average Government contribution the amount of any excess Government contribution paid to employees and annuitants under subsection (c)(1) of this section. The Office shall then adjust such average contribution rates by the percentage change (as determined by the Office) in the implicit price deflator for the gross national product for the calendar quarter ending March 31 immediately preceding such plan year, relative to the implicit price deflator for the gross national product for the calendar quarter ending the preceding March 31, as such quarterly figures are published by the Bureau of Economic Analysis of the Department of Commerce.

"(3) The Office shall provide for conversion of biweekly rates of Government contributions and enrollee premiums determined under this section to rates for employees and annuitants paid on other than a biweekly basis, and for this purpose may provide for the adjustment of the coverted rate to the nearest cent.

"(b)(1) Except as provided by paragraph (2) of this subsection and paragraph (2) of subsection (e) of this section, for all periods during which an enrollment under this chapter continues, a Government contribution, as determined by the Office under subsection (a) of this section, shall be payable on behalf of each enrolled employee and annuitant. For employees, adjustments in the Government premium contribution rates computed by the Office in accordance with subsection (a) of this section and changes in health benefits plan premium rates shall take effect on the first day of the first pay period beginning on or after the beginning of the plan year. For an annuitant, the adjustments in contribution and premium rates shall take effect on the first day of the plan year.

"(2) In the case of an enrolled employee who is occupying a position on less than a full-time basis, the biweekly Government contribution shall be an amount which bears the same ratio to the adjusted contribution rates determined under subsection (a) of this section as the average number of hours of such employee's regularly scheduled workweek bears to the average number of hours in the regularly scheduled workweek of an employee serving in a comparable position on a full-time basis (as determined under regulations prescribed by the Office).

"(c)(1) Each employee or annuitant who elects to enroll in a qualified health benefits plan under this chapter shall be responsible for payment of any group premium charge applicable to such enrollment in excess of the biweekly Government contribution authorized under subsection (b) of this section for each pay period during which the enrollment continues. Withholdings for this purpose shall be made from the pay of each enrolled employee and the annuity of each enrolled annuitant.

"(2) If the periodic Government contribution rate authorized under subsection (b) of this section for self-only or self-and-family health plan enrollments exceeds the periodic premium charge for an approved health benefits plan and enrollment category selected by an eligible employee or annuitant under this chapter, the excess Government contribution shall be paid directly to the enrolled employee or annuitant each pay period in accordance with subsections (f) and (g) of this section, but only to the extent that such excess amount does not exceed 40 percent of the authorized Government contribution rate.

"(d) In addition to Government contributions authorized under subsection (b) of this section, there shall be contributed by the Government for each enrollment an amount which the Office determines to be necessary for administrative costs in accordance with section 8906(b) of this title.

"(e)(1) An employee enrolled in a health benefits plan under this chapter who is placed in a leave without pay status may have his coverage and the coverage of his family members continued under the plan for not to exceed one year, subject to payment of the appropriate amounts by the Government and the enrollee as required by subsections (b) and (c) of this section.

"(2) An employee who enters on approved leave without pay to serve as a full-time officer or employee of a labor organization, as defined by section 7103(a)(4) of this title, may, within 60 days after entering on that leave without pay, file with his employing agency an election to continue his enrollment under this chapter and arrange to pay currently into the Employees Health Benefits Fund, through his employing agency, both employee and agency contributions from the beginning of the period of leave without pay. The employing agency shall forward the enrollment charges so paid to the Office for deposit to the Fund. If the employee does not so elect, his enrollment will be subject to paragraph (1) of this subsection and implementing regulations.

"(f) The Government contributions toward health plan premiums and administrative costs under this section for an employee, and any payments to employees under subsection (c)(2) of this section, shall be paid—

"(1) in the case of employees generally, from the appropriation or fund which is used to pay the employee;

"(2) in the case of an elected official, from an appropriation or fund available for payment of other salaries of the same office or establishment;

"(3) in the case of an employee of the legislative branch who is paid by the Clerk of the House of Representatives, from the contingent fund of the House; and

"(4) in the case of an employee in a leave without pay status, from the appropriation or fund which would be used to pay the employee if he were in a pay status.

"(g)(1) Except as provided in paragraphs (2), (3), and (4) of this subsection, Government contributions toward health plan premiums and administrative costs authorized under this section relative to annuitant enrollments under this chapter, and any payments to annuitants under subsection (c)(2) of this section, shall be paid by the Office from annual appropriations which are authorized to be made for that purpose and which may be made available until expended.

"(2) In the case of annuitants who are retired officers or employees of the United States Postal Service or the Post Office Department, or the survivors of such individuals, the United States Postal Service shall pay all Government contributions authorized by this section and shall forward contributions required by subsections (b) and (d) of this section to the Employees Health Benefits Fund upon notification by the Office of the amounts which the Office determines are necessary for this purpose.

"(3) In the case of annuitants who are retired officers or employees of the government of the District of Columbia, or the survivors of such individuals, the District of Columbia government shall pay all Government contributions authorized by this section and shall forward contributions required by subsections (b) and (d) of this section to the Employees Health Benefits Fund upon notification by the Office of the amounts which the Office determines are necessary for this purpose.

"(4) In the case of annuitants who receive monthly compensation under subchapter I of chapter 81 of this title, all Government contributions authorized by this section shall be paid from the Employees' Compensation Fund established by subsection (a) of section 8147 of this title, with such contributions charged back to the former employing agency in accordance with subsection (b) of such section. The Secretary of Labor shall authorize payment to the Employees Health Benefits Fund of contributions required by subsections (b) and (d) of this section upon notification by the Office of the amounts the Office determines are necessary for this purpose.

"(h)(1) In accordance with regulations prescribed by the Office, an employing agency or retirement system which fails to collect and forward enrollee premium contributions, along with Government contributions toward health plan premiums and administrative expenses, to the Office in the correct amounts and in a timely manner for deposit to the credit of the Employees Health Benefits Fund shall be liable for the appropriate amounts, plus interest at a rate determined by the Office and computed from the time such payment should have been forwarded to the Office.

"(2) If an agency fails to withhold the proper amount of health benefits premium contributions from an individual's salary, compensation, or retirement annuity, the collection of unpaid premiums may be waived by the agency if, in the judgment of the agency, the individual is without fault and recovery would be against equity and good conscience. However, if the agency so waives the collection of unpaid enrollee premium contributions, the agency shall submit an amount equal to the sum of the uncollected enrollee contributions and appropriate Government contributions, plus interest, as required by paragraph (1) of this subsection.

"(i) The Office shall forward enrollee premium contributions and applicable Government premium contributions for enrollees in each health benefits plan to the carrier no later than 30 days after such moneys are received by the Office for deposit to the Employees Health Benefits Fund.

"§ 8905. Coverage of reinstated employees and restored annuitants

"(a) An employee enrolled in a health benefits plan under this chapter who is removed or suspended without pay and later reinstated or restored to duty on the grounds that the removal or suspension was unjustified or unwarranted may, at his option, be issued a health care voucher for purposes of enrolling as a new employee or have his coverage restored, with appropriate adjustments made in contributions and claims, to the same extent and effect as though the removal or suspension had not taken place.

"(b) A disability annuitant whose annuity under section 8337 of this title, or a similar provision of another retirement system for employees of the Government, is terminated because the annuitant recovers from disability or is restored to an earning capacity fairly comparable to the current rate of pay of the position occupied at the time of retirement, and whose annuity is later restored due to recurrence of the disability or loss of earning capacity, shall upon such restoration, be issued a health care voucher by his retirement system for purposes of enrolling in a health benefits plan under this chapter, if such annuitant was covered by any such plan immediately prior to the termination of the annuity.

"(c) A surviving spouse whose survivor annuity under this title was terminated because of remarriage and is later restored shall, under such regulations as the Office of Personnel Management may prescribe, be issued a health care voucher by the retirement system for purposes of enrolling in a health benefits plan under this chapter, if such spouse was covered by any such plan immediately before such annuity was terminated.

"§ 8906. Employees Health Benefits Fund

"(a) There is hereby established in the Treasury of the United States an Employees Health Benefits Fund which shall be administered by the Office of Personnel Management. The contributions of employees, annuitants, and the Government toward health plan premium charges and administrative expenses prescribed by section 8904 of this title shall be paid into the Fund. The Fund, other than accounts identified for specific purposes under this section and the Retired Federal Employees Health Benefits Act (74 Stat. 850), is available, without fiscal year limitation, for payments by the Office to approved health benefits plans of premium charges with respect to enrollments under this chapter.

"(b) An amount, as determined by the Office to be necessary from time to time, but not to exceed one percent of the Government contribution rates as determined by the Office pursuant to section 8904(a)(2) of this title, shall be set aside from Government contributions paid into the Fund for each enrollment during a plan year under section 8904 of this title as an administrative expense reserve, to be available, within the limitations that may be specified annually by Congress, to pay the administrative expenses incurred by the Office under this chapter.

"(c) There shall be an enrollees' contingency reserve account in the Fund. The Office, from time to time and in amounts it considers appropriate, may transfer any amounts credited to the general Employees Health Benefits Fund in prior plan years in excess of premiums due carriers to the enrollees' contingency reserve account. Such account shall be available to the Office, without fiscal year limitation, for payment of any expenses which the Office may, in its discretion, consider proper for the benefit of individuals enrolled in health plans under this chapter.

"(d) The Secretary of the Treasury may invest and reinvest any of the money in the Fund which is not immediately required for premium payments to carriers, administrative expenses, or authorized disbursements from the enrollee contingency reserve, in interest-bearing obligations of the United States, and may sell these obligations for the purposes of the Fund. The interest on, and the proceeds from the sale of, these obligations shall become a part of the enrollees' contingency reserve in the Fund as authorized under subsection (c) of this section.

"§ 8907. Studies and reports

"(a) The Office of Personnel Management shall make a continuing study of the operation and administration of this chapter, including surveys and reports on health benefits plans available to employees and on the experience of the plans.

"(b) Each Government agency shall keep such records, make such certifications, and furnish the Office with such information and reports as may be necessary to enable the Office to carry out its functions under this chapter.

"§ 8908. Jurisdiction of courts

"The district courts of the United States have original jurisdiction, concurrent with the Court of Claims, of a civil action or claim against the United States founded on this chapter.

"§ 8909. Regulations

"(a) The Office of Personnel Management shall prescribe regulations necessary to carry out the purposes of this chapter.

"(b) The regulations of the Office may exclude an employee from coverage under this chapter on the basis of the nature and type of his employment or conditions pertaining to it, such as short-term appointments, seasonal or intermittent employment, and employment of like nature. The Office may not exclude—

"(1) an employee or group of employees solely on the basis of the hazardous nature of employment;

"(2) a teacher in the employ of the Board of Education of the District of Columbia, whose pay is fixed by section 1501 of title 31, District of Columbia Code, on the basis of the fact that the teacher is serving under a temporary appointment if the teacher has been so employed by the Board for a period or periods totaling not less than two school years; or

"(3) an employee solely on the basis of occupying a position on a part-time career employment basis (as defined in section 3401(2) of this title).

"(c) The regulations of the Office shall provide for the beginning and ending dates of coverage of employees and annuitants and their family members under health benefits plans. The regulations may require the coverage to continue, exclusive of the temporary extension of coverage described by section 8902(a)(8) of this title, until the end of the pay period in which an employee is separated from the service, or until the end of the month in which an annuitant ceases to be entitled to annuity, and in case of the death of an employee or annuitant, may permit a temporary extension of the coverage of his family members for not to exceed 90 days.

"(d) The Secretary of Agriculture shall prescribe regulations to effect the application and operation of this chapter to an individual named by section 8901(1)(H) of this title.".

(b)(1) The amendments made by subsection (a) of this section shall take effect on October 1, 1984, except that the Office of Personnel Management shall take such steps as it considers necessary prior to that date, including scheduling a special open enrollment season, to ensure that such provisions are successfully implemented beginning on that date. The Office may, with respect to enrollees in health benefits plans under chapter 89 of title 5, United States Code, before October 1, 1984, automatically assign any individuals who do not specify a choice with respect to health plan coverage effective on and after that date to an appropriate level of benefits in a successor plan offered by the same carrier, or, in the event such carrier is no longer a participant under this chapter, to a plan which the Office determines is reasonably similar to the individual's health plan coverage under this chapter before October 1, 1984, unless the individual enrollee gives notice in accordance with regulations prescribed by the Office that the automatic assignment is unacceptable.

(2) Any carrier that, on the day before the effective date of the amendments made by subsection (a), is operating a health benefits plan under chapter 89 of title 5, United States Code, as in effect before the amendments made by subsection (a), shall not be subject to the requirements of section 8902(a)(9) of such title, as enacted by this Act, if the Office of Personnel Management determines such carrier to be financially stable.

SEC. 3. (a) Effective beginning on the date of the enactment of this Act, section 8902(a) of title 5, United States Code (as in effect on such date), is amended by adding at the end thereof the following new sentence: "Notwithstanding the preceding sentence, all contracts under this chapter shall terminate effective September 30, 1984.".

(b) Contingency reserve funds set aside in the Employees Health Benefits Fund for individual health benefits plans under section 8909(b)(2) of title 5, United States Code, as in effect on September 30, 1984, shall, for the 2-year period beginning on that date, remain available to pay accrued claims against the respective health benefits plans to the extent that the Office of Personnel Management determines that other reserves held by the carrier of a terminated plan are insufficient to liquidate outstanding claims. Effective October 1, 1986, the Office shall determine the total of any individual health plan contingency reserve accounts remaining in the Employees Health Benefits Fund, and shall transfer all such contingency reserve funds, together with any interest income earned from the investment of such funds by the Secretary of the Treasury in interest-bearing obligations of the United States, to the enrollees' contingency reserve account established in the Employees Health Benefits Fund pursuant to section 8906(c) of title 5, United States Code (as enacted by this Act).

(c) Any unused administrative reserve funds set aside in the Employees Health Benefits Fund under section 8909(b)(1) of title 5, United States Code, as in effect immediately before October 1, 1984, shall be available, without fiscal year limitation, to pay administrative expenses incurred by the Office in implementing the provisions of this Act.

(d) The balance in the Employees Health Benefits Fund immediately before October 1, 1984 (exclusive of funds under subsection (b) or (c) of this section), shall remain available in such Fund for expenditure in accordance with section 8906 of title 5, United States Code (as in effect prior to the enactment of this Act).

SEC. 4. (a) The Retired Federal Employees Health Benefits Act (74 Stat. 849) is amended as follows:

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(1) Strike out the term "Commission" each place it appears and insert in lieu thereof "Office of Personnel Management".

(2) Section 2(1) is amended to read as follows:

"(1) The term 'employee' and the term 'Government' each has the meaning given such term by section 8901 of title 5, United States Code.".

(3) Sections 3, 5, and 10 are repealed.

(4) Section 4 is amended by striking out the first two sentences of such section and inserting in lieu thereof the following: "If a retired employee enrolls for self-only in a health benefits plan as provided for by section 6 of this Act, the Government shall contribute each month toward his subscription charge an amount equal to the current monthly premium of an individual under section 1839(a)(3) of the Social Security Act.".

(5) Section 6(a) is amended in the first sentence thereof by striking out ", other than the plan provided for under section 3 of this Act,".

(6) Section 7 is amended to read as follows:

"ELECTIONS

"SEC. 7. Each retired employee shall, within such time after March 1, 1961, as the Office of Personnel Management shall prescribe, notify the Office of his election to enroll in or retain existing coverage in a private health benefits plan and

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receive Government contributions under section 6 of this Act, or not to participate in the program offered under this Act. If the retired employee elects to enroll under this section, his election shall be accompanied by a certificate of the carrier certifying the fact of his enrollment and the cost to him of the health benefits plan, or of the health benefits portion of the plan.".

(7) Section 8 is amended to read as follows:

"HEALTH BENEFITS FUND

"SEC. 8. (a) The Government contributions provided under sections 4 and 6 of this Act, and expenses incurred by the Office of Personnel Management in the administration of this Act, shall be paid from funds that shall be credited for this purpose by the Secretary of the Treasury, out of money in the Treasury of the United States which is not otherwise appropriated, to the Employees Health Benefits Fund established in the Treasury of the United States under chapter 89 of title 5, United States Code, upon notification by the Office of the amounts which the Office determines are necessary for purposes of this section.

"(b) The funds credited to the Employees Health Benefits Fund under subsection (a) of this section shall be available without fiscal year limitation for payment of the Government contributions provided under sections 4 and 6 of this Act through agencies of the Government which administer a retirement system for employees of the Government and for expenses incurred by the Office in administering this Act.".

(8) The first sentence of section 9(b) is repealed.

(9) Section 9(c) is amended—

(A) by striking out ", and withholdings required by section 5 of this Act" in paragraph (4);

(B) by striking out paragraph (6); and

(C) by striking out "and withholding" in paragraph (8).

(10) Section 12 is amended by striking out "and withholdings".

(b) The amendments made by subsection (a) shall take effect beginning on January 1, 1984. On that date, all moneys then credited to the Retired Employees Health Benefits Fund in the Treasury of the United States shall, except as provided by subsection (d), be transferred to the Employees Health Benefits Fund established by section 8909 of title 5, United States Code, and set aside for purposes of the Retired Federal Employees Health Benefits Act.

(c) Each individual enrolled in the Government-wide plan pursuant to section 3 of the Retired Federal Employees Health Benefits Act on December 31, 1983, shall be automatically transferred to an appropriate level of benefits under the indemnity benefit plan described in paragraph (2) of section 8903 of title 5, United States Code (as in effect on the date of enactment of this Act), effective January 1, 1984, unless the individual elects, in accordance with such procedures as the Office of Personnel Management by regulation prescribes, to enroll in another type of plan described in such section.

(d) Effective January 1, 1984, any contingency reserve to the credit of the Government-wide plan under the Retired Employees Health Benefits Act, and any moneys received on or after that date with respect to enrollments in such plan, shall be transferred to the contingency reserve of the indemnity benefit plan (referred to in subsection (c) in the Employees Health Benefits Fund established under section 8909(b) of title 5, United States Code, which contingency reserve shall be made available for payment of any outstanding obligations of the terminated Government-wide plan.

O

EXTENSIONS OF REMARKS

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

HON. WILLIAM E. DANNEMEYER
OF CALIFORNIA
IN THE HOUSE OF REPRESENTATIVES

Thursday, August 4, 1983

● Mr. DANNEMEYER. Mr. Speaker, at the request of the administration, it is my privilege to introduce a bill to authorize a new concept of care and economy for the Federal employees health benefits program (FEHBP)—the voucher. I urge early and comprehensive hearings on this important initiative and trust that my colleagues will give this proposal serious consideration.

The voucher is an expansion of, not a departure from, the current FEHBP which features multiple choice of health plans and fixed-dollar subsidies. However, the choice could be greater, the cost more predictable, and the cost-reducing incentives more effective.

While there are more than 130 plans in the FEHBP, the average Federal worker has access to an average of only 12 plans. Only 5 plans offer both low- and high-option coverage. Only the 2 Government-wide plans and 7 of the 11 employee organization plans open to all Government employees accepted retired workers in 1982. Choice is limited for active and retired Federal workers under the current program.

This voucher proposal would permit any State-licensed plan, subject to Federal financial soundness criteria, to participate. All plan records would be open to inspection by the Office of Personnel Management and the General Accounting Office. The OPM would specify minimum catastrophic coverage for all plans.

The unpredictability of Government costs and the Government's underpricing of premiums in 1979 and 1980 led to the chaos in 1981 which required that benefits be cut, premiums be raised and that open season be delayed. Currently, the Government contribution is driven by the so-called Big Six plans. The amount the Government pays to any plan is 60 percent of the unweighted average of the Big Six rates, not to exceed 75 percent of an individual plan's rate. OPM negotiates with carriers over both rates and benefits.

Under this voucher plan, the payment would be tied to the average of all (not low options as some reported) self and self and family premiums paid in 1984 and indexed to the GNP deflator. OPM would not longer negotiate premiums and benefits. The voucher plan would require the Postal Service and District of Columbia as off-budget agencies to pay the employer's share of retirees' premiums. The general Treasury now pays that share.

The 75-percent cap biases plans against offering lower option coverage. As a result of the cap, the Government pays a larger dollar amount for high-cost plans. This creates a disincentive to enroll in and thus to offer lower-cost plans. This deters competition among carriers for lower-cost coverage. This leads to higher Government and employee contributions.

The voucher would pay 100 percent of the indexed 1984 average premium. If a plan cost less, the difference (up to a certain amount) would be rebated to the employee. If the employee desired greater coverage, he or she would pay the difference out of pocket. Under this bill, the voucher program would become effective October 1, 1984.

The voucher plan is dedicated to the proposition that you can cut costs without cutting the quality of care or people's access to it. Some believe the voucher may lead to reduced benefits, loss of cost control over carriers, and unacceptable costs for those employees, active or retired, with greater medical need. In short, some believe that medical need is inelastic, that most people are risk averse, and that premiums and benefits should be regulated by the Government. In that view, the job of government is to preserve a maximum benefit structure.

It is my view that opposition to the voucher is premature, based upon a one-sided reading of the 1959 Act, and the result of misconceptions about medical care and need.

We should give the voucher concept a chance in legislative proceedings. I have questions (discussed later) and convictions about its potential. Let us have a thorough review of a concept that may be constructively applied to the exploding costs of the medicare program.

Clearly, the act calls for the Government (that is OPM) to negotiate rates and benefits to achieve a package comparable to larger employers and progressive industry. The goal is to "assure maximum health benefits at the lowest possible cost to (employees) and to the Government" (House Report 86-958, page 4). The purpose is to provide for competitive recruitment and retention of competent personnel.

According to a 1983 GAO report (HRD-83-21) and the 1982 Mercer report, the FEHBP falls somewhat short of what the private sector offers in benefits and pays as employers.

The remedy urged by some is to mandate benefits in law (none are specified now), to add new beneficiaries, and for Government to spend more. This is the approach taken in H.R. 656 which the House Post Office and Civil Service Subcommittee on Compensation and Employee Benefits is now considering.

How should we reach private sector comparability? It is my view that the answer to comparability is to permit more competition rather than to increase regulation. Indeed, I would note that many Federal labor representatives opposed the provision in H.R. 656 that would mandate certain benefits under law. With respect to Government contributions, James J. LaPenta, Jr., director of the Mail Handlers Health Benefit plan made an interesting point in his subcommittee testimony:

> I recognize that Congress has not only an obligation to Federal and postal employees, but also an obligation to the taxpayers to keep total program costs within reasonable and manageable limits. Furthermore, because the Federal contribution is based on an average of the annually changing premium levels of the Big Six plans, the total Federal cost is variable and unpredictable. This lack of predictability can lead, as it did in 1981, to last-minute crises and arbitrary and unfair * * * cuts * * * (We) would support a measure placing a limit on the amount by which the Government contribution could increase in any given year. That limit, however, should not arbitrarily tie the Government's contribution to some standard unrelated to costs in the program.

It is my view that we can only achieve a balance between maximum benefits and acceptable costs through a marketplace mechanism such as a voucher. The choice is between more regulation or more competition. The debate is over the control of benefits rather than the level of benefits. The alternative to a consumer-choice system is a provider-dominated system. The act calls for comparability to progressive industry. Let us be sure that our legislative remedies are progressive.

The fear that a voucher abandons the consumers and cost control is based on misconceptions about medical care. The chief misconception is that more services—more care—better health. In an excellent little book (on another alternative health care financing system) called "Health Plan," Dr. Alain C. Enthoven of Stanford University debunks these and other misconceptions about medical care. He states:

> * * * a financing system that motivates giving more rather than less care is not necessarily leading doctors to give better care or to produce better health.

The result of adopting a static view of medical need and care is a call for public utility regulation and resistance to financial incentives.

The voucher would force carriers to examine and control provider costs if they want to keep enrollees who receive a fixed-dollar subsidy. The

● This "bullet" symbol identifies statements or insertions which are not spoken by the Member on the floor.

voucher puts the heat on carriers and providers, not the consumer!

This is not a black and white issue. We are talking about the grey areas of more regulation versus more competition. It is my view that the ~~administration's proposal is a good starting point~~ for discussion ~~but not the last word. Below are some of my concerns.~~

Should the proposal address the potential for abusive marketing practices by new carriers?

Should the law require all plans to accept retirees in order to provide fair competition?

Does the proposal permit plans to use preexisting medical conditions as a limitation on benefits?

Should OPM require all plans to quote premiums for at least one standard package of benefits in order to facilitate comparison?

Should the voucher pay more for the old than the young? Should voucher payments be linked to categories of enrollees' risk level, in order to reduce adverse selection?

Is the GNP deflator a reasonable index? Should another index be used?

Should the voucher program provide that enrollees will be held harmless from plans that go bankrupt?

I favor a workable system of fair competition intended to make affordable health insurance available to Federal employees. The choice is how we get there—through more regulation or more competition.

Mr. Speaker, at this point ~~I request~~ that a ~~summary of the bill be included.~~

SUMMARY

A bill to restructure the Federal Employees Health Benefits Program to strengthen financial control over the Program and enhance competition among participating health plans, and for other purposes

The FEHB Program needs major reform to set it on a firm course for the future, so that the interests of enrollees and the Government are protected. This bill is designed to preserve the best features of the current Program while solving the problems.

SECTION 1

This act may be cited as the "Federal Employees Health Benefits Reform Act of 1983."

SECTION 2

Subsection 2(a) of the bill would revise and reenact the current Federal Employees Health Benefits (FEHB) law (5 U.S.C., ch. 89) as follows:

Section 8901—Definitions

The definitions in the current section 8901 would be essentially reenacted with the notable exception of "carrier." The new definition would broaden health plan participation to include (A) Government-wide, regional, or local plans offered by one or more Blue Cross and Blue Shield corporations or by any legal entity licensed to market group health insurance in the State in which the plan is offered; (B) additional employee organization-sponsored plans; and (C) all Federally qualified health maintenance organizations (HMO's).

Section 8902—Qualified health benefits plans

The law would no longer authorize OPM to contract with carriers for FEHB plans. Eligible carriers would be required to submit proposed plans for OPM approval which would be accorded if the carrier certifies that group insurance benefits will be offered to all eligible FEHB participants: (1) at rates consistent with the carrier's lowest schedule of rates for comparable polices; (2) in accordance with minimum catastrophic protection requirements specified by OPM regulations; and (3) with acceptable conversion rights upon involuntary termination of group eligibility. Reinsurance requirements would ensure the financial stability of plans.

This section also requires carriers to provide enrollees with a detailed plan description in a format approved by OPM, to grant OPM and GAO access to plan records, and to have in place a satisfactory utilization review system.

Section 8903—Enrollment procedures

This section essentially reenacts current provisions of law.

Each employing office and retirement system would be required to issue to their eligible employees and annuitants such materials as OPM may prescribe for purposes of facilitating a choice among available health benefits plans, including: a list of plans and their respective premium rates, instructions for obtaining detailed information on benefits from carriers, and a health care voucher form on which to register a choice of plan. OPM would see to it that comparative information on plans is made available to enrollees.

Section 8904—Government contributions and enrollee premiums

The most important correction needed is in calculating the Government contribution to health benefits premiums. The current formula which ties that contribution to the average premium for the highest level of benefits offered by six of the plans with the largest FEHB enrollments is too unpredictable. The proposal would replace this formula with specified contribution rates which would be amounts equal to the average Government contribution rate in the preceding plan year for self-only and self-and-family enrollments, respectively, indexed in accordance with the percentage change in the implicit price deflator for the Gross National Product over the 12-month period ending March 31 preceding each plan year, as determined by OPM based on GNP calculations published by the Bureau of Economic Analysis of the U.S. Department of Commerce.

Another change would be to ~~eliminate the current 75 percent limitation~~ on the Government contribution toward the cost of a particular plan or level of benefits in order to encourage enrollees to select lower cost plans, possibly at no enrollee cost. Moreover, ~~if an enrollee elects a health plan with a premium cost below the available Government contribution, the enrollee would be entitled to receive a cash rebate~~ equal to the amount of any excess Government contributions, ~~except that such rebate may not exceed 10 percent of the authorized Government contribution in each use. Health plan premiums in excess of the basic Government~~ ment ~~contribution would be withheld from the enrollee's pay or annuity.~~

In addition to the basic Government contribution, Government agencies would contribute an amount for each enrollment, as determined necessary by OPM but not to exceed one percent of the basic Government premium contribution rate, to fund OPM's administration of the law. Expenditures for administrative expenses would be subject to limitations imposed each year by Congress. ~~OPM would continue to receive all Government contributions and enrollee withholdings and to forward appropriate payments to participating health plans.~~

The proposal would further improve Program financing by requiring the Postal Service and the District of Columbia government to assume responsibility for payment of Government contributions on behalf of their retired employees, or their survivors, as well as requiring the Department of Labor to make contributions on behalf of recipients of workers' compensation benefits and charge such amounts back to the former employing agency.

Section 8905—Coverage of reinstated employees and restored annuitants

This section essentially reenacts 5 U.S.C. 8908.

§ 8906. Employees Health Benefits Fund

In addition to the existing administrative reserve, an enrollees' contingency reserve account would be established in the Fund, to which OPM may credit any amounts which accrue to the general Fund in excess of premium payments due carriers and, pursuant to section 3 of the bill, any balance remaining in existing health plan contingency reserve accounts in the Fund at the end of two years after termination of final contracts entered into under current provisions of 5 U.S.C. 8902. The newly created reserve would be available, without fiscal year limitation, for payment of expenses which OPM deems proper for the benefit of FEHB enrollees.

Section 8907.—Studies and reports

This section essentially reenacts 5 U.S.C. 8910.

Section 8908.—Jurisdiction of courts

This section essentially reenacts 5 U.S.C. 8912.

Section 8909.—Regulations

This section substantially reenacts 5 U.S.C. 8913.

Section 2(b) of the bill would make the amendments to chapter 89 of title 5, United States Code, effective with respect to health plan enrollments and Government contributions on and after October 1, 1984. To ensure that the new provisions will be fully implemented on the specified effective date, the bill would authorize OPM to automatically assign current FEHB enrollees who do not specify a choice with respect to health plan coverage under the new program to an appropriate successor health plan. Also, section 2(b) would permit currently operating FEHB plans to continue under the new program without meeting the new reinsurance requirements, provided they are financially stable.

SECTION 3

Section 3(a) would amend existing FEHB law to provide that all contracts which become effective in January 1984 shall terminate effective September 30, 1984.

Section 3(b) would provide that any balance in health plan contingency reserve accounts in the Employees Health Benefits Fund shall be transferred to the enrollees' contingency reserve account established under section 8906(c) of title 5, United States Code, as amended by section 2 of this bill, effective October 1, 1986.

Section 3(c) would provide that the administrative reserve account in the Employees Health Benefits Fund immediately prior to the effective date of section 2 of this bill shall be available without limitation to meet OPM's expenses for implementation of this law.

SECTION 4

The retired Federal Employees Health Benefits Act would be amended to abolish the Government-wide Uniform Plan, effective December 31, 1983. Then, effective Jan-

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uary 1, 1984, any remaining Uniform Plan enrollees would be automatically transferred to an appropriate level of benefits under the Government-wide Indemnity Benefit Plan under the FEHB Program.●

THE RIDE

HON. EDWARD J. MARKEY

OF MASSACHUSETTS

IN THE HOUSE OF REPRESENTATIVES

Thursday, August 4, 1983

● Mr. MARKEY. Mr. Speaker, I would like to bring to the attention of my colleagues a most worthwhile effort to meet the transportation needs of the physically disabled in three of the communities I represent.

The barriers which confront handicapped people should be a constant concern for all Americans. Those without disabilities too often forget the difficulties faced by the handicapped. Fortunately, the Massachusetts Bay Transportation Authority (MBTA) understands this problem and has taken a significant step toward countering the physical barriers which confront disabled people in their daily activities.

On August 8 the MBTA will begin "The Ride" program in the communities of Everett, Chelsea and Winthrop. "The Ride" is a door-to-door transportation system for individuals who are physically disabled and prevented from using public transportation.

"The Ride" is the first disabled transportation service in the suburbs of Boston. This program has already been established and has been very successful in that city and the cities of Cambridge and Brookline.

The program's wheelchair-equipped van will run 7 days a week with a fare of only 75 cents, making it much easier for handicapped citizens to travel about their communities.

Unfortunately, we have seen the Reagan administration pursue sharp reductions in Federal services and programs for the handicapped, shifting a greater share of the responsibilities to the cities and the States. I am proud to say that my home State, and in particular the MBTA, has taken an active role in the efforts to meet the needs of the physically disabled.

"The Ride" should serve as an example for State, Federal, and local governments throughout our Nation.

I commend the MBTA and in particular General Manager James O'Leary and Massachusetts Governor Michael Dukakis for continuing this worthwhile program, and on behalf of the people of Everett, Chelsea, and Winthrop, I welcome "The Ride."●

KEY VOTES

HON. DONALD J. PEASE

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Thursday, August 4, 1983

● Mr. PEASE. Mr. Speaker, it has become my practice to periodically insert in the CONGRESSIONAL RECORD a list of key votes that I have cast in the U.S. House of Representatives.

The list is arranged in this manner: Each item begins with the number of the bill or resolution that the House was considering and is followed by a summary of the vote. This is followed by my own vote on the issue, whether the matter passed or failed, and the vote outcome.

This list of votes covers the period of January 3, 1983 to May 26, 1983.

(5) H. Res. 5. Rules of the House. Vote to reject an effort to change a new rule allowing the Committee of the Whole House to "rise" before consideration of each legislative rider to an appropriations bill. No. Defeated 156-250.

(10) H.R. 999. Suspension of the rules to pass a bill establishing an American Conservation Corps, which would provide grants to various federal agencies, state governments, and Indian tribes to hire youth for summer and year-round employment. Yes. Passed 301-87.

(12) H.R. 1310. Amendment would have deleted $20 million for national teaching scholarships and instead provided $50 million for a Presidential Mathematics and Science Education Fund. No. Failed 92-323.

(14) H.R. 1310. Bill authorized $325 million to improve math and science education and $100 million to promote the training and use of scientific and technical personnel. Yes. Passed 348-54.

(18) H.R. 1718. An amendment to the Emergency Supplemental Appropriations for fiscal year 1983 requiring that 75 percent of the money for discretionary programs in the bill be targetted to areas of high unemployment. Yes. Passed 335-83.

(20) H.R. 1718. Emergency Supplemental Appropriations for fiscal year 1983. The bill appropriated $4.9 billion in additional funds for programs intended to create jobs and $5.7 billion for advances to the Federal Unemployment Trust Fund. Yes. Passed 324-95.

(21) H.R. 1296. Payment-in-kind Tax Treatment Act of 1983. Suspension of the rules to permit farmers to defer income tax payment on commodities received under the Agriculture Department's 1983 payment-in-kind (PIK) program until those commodities are sold. Yes. Passed 401-1.

(22) H.R. 1900. Amendment raising the normal Social Security retirement age by 2 years to be phased in by 2027. Retirement at age 62 would still be possible, but at a lower percentage of full benefits than provided currently. No Passed 228-208.

(26) H.R. 1900. Final passage of comprehensive Social Security Act amendments, enacting various changes in the Social Security system designed to ensure its solvency. Yes. Passed 282-148.

(38) H.R. 1149. Bill designating as wilderness 30 areas of national forest and public lands in Oregon totaling 1.1 million acres, and setting aside an additional 98,000 acres for further wilderness study. Yes. Passed 252-93.

(41) H. Con. Res. 91. Rule for consideration of the First Concurrent Budget Resolution. Provided for major substitute to be offered on behalf of the President. Yes. Passed 230-187.

(46) H. Con. Res. 91. First Budget Resolution for fiscal year 1984 setting targets of $936.6 billion in budget authority, $836.6 billion in outlays, $689.1 billion in revenues, and allowing for a deficit of $174.5 billion. Yes. Passed 229-196.

(51) H.R. 1437. California Wilderness Act. Bill added 2.3 million acres in 58 areas of California to the national wilderness system, set aside 72,000 acres for further wilderness study, added 17,000 acres to the national park system, and designated 1.4 million acres of national park land as national park wilderness. Yes. Passed 297-96.

(79) H.R. 1190. Emergency Agricultural Credit Act. Bill temporarily liberalized Farmers Home Administration loans and repayment schedules to reflect the current adverse farm situation. Yes. Passed 378-5.

(89) H.J. Res. 13. (Nuclear Weapons Freeze, round II.) Passage of bill calling for a mutual and verifiable nuclear freeze on weapons in U.S. and Soviet arsenals. Yes. Passed 278-149.

(92) H.R. 2174. Federal Anti-Tampering Act. The bill made it a federal crime to knowingly tamper with a product designed to be ingested or consumed if such tampering were in reckless disregard for the risk of death or injury to the purchaser of the product. Yes. Passed 292-0.

(102) H.R. 1983. Amendment to the Emergency Housing Assistant Act which would have deleted $760 million to assist home owners facing foreclosure on home-mortgage loans. No. Failed 197-220.

(106) H.R. 1983. Emergency Housing Assistance Act. The bill established a revolving loan fund to assist homeowners who are facing foreclosure on home mortgage loans not insured by the FHA or FmHA and provided assistance for shelter and essential services for the homeless. Yes. Passed 216-196.

(109) H.R. 2066. Amendment to the National Science Authorization that would have cut the authorization for research instrumentation by $50 million. No. Failed 150-257.

(111) H.R. 2066. Bill authorizing $1.34 billion for the National Science Foundation Authorization for fiscal year 1984. Yes. Passed 297-111.

(112) H.R. 2587. Amendment to Energy Department Civilian R&D Authorization for fiscal year 1984 prohibiting the use of funds in fiscal year 1984 to either continue or terminate the Clinch River Breeder Reactor project unless Congress subsequently enacts cost-sharing legislation. Yes. Passed 388-1.

(114) H.R. 2587. Amendment to the Energy Department Civilian R&D Authorization for 1984 that would have reduced overall funding by approximately $310 million. No. Failed 140-228.

(116) H.R. 2587. Energy Department Civilian Research and Development Authorization of $3.3 billion for fiscal year 1984. Yes. Passed 230-132.

(123) H.R. 2973. Suspension of rules to repeal Tax Withholding on Interest and Dividend Income. The bill repealed the provisions of the Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248). Yes. Passed 382-41.

(129) H.R. 2990. Rule on the Increase in Public Debt Limit which barred all amendments other than committee amendment. Yes. Passed 263-156.

(132) H.R. 2948. Suspension of the rules to pass Veterans' Housing Benefits Amendments. The bill provided up to $8,400 in loans to veterans facing foreclosure on

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98TH CONGRESS
1ST SESSION

H. R. 656

To amend the Federal employee health benefit plan provisions of chapter 89 of title 5, United States Code, to increase the Government contribution rate, to extend coverage for employees who are separated due to reductions in force, to require carriers to obtain reinsurance or stop-loss insurance (or to otherwise demonstrate financial responsibility), to assure adequate mental health benefit levels and otherwise limit benefit reductions, to mandate an open season each year, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JANUARY 6, 1983

Ms. OAKAR introduced the following bill; which was referred to the Committee on Post Office and Civil Service

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A BILL

To amend the Federal employee health benefit plan provisions of chapter 89 of title 5, United States Code, to increase the Government contribution rate, to extend coverage for employees who are separated due to reductions in force, to require carriers to obtain reinsurance or stop-loss insurance (or to otherwise demonstrate financial responsibility), to assure adequate mental health benefit levels and otherwise limit benefit reductions, to mandate an open season each year, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SHORT TITLE; TABLE OF CONTENTS

SECTION 1. (a) This Act may be cited as the "Federal Employees Health Benefits Reform Act of 1983".

(b) The table of contents for this Act is as follows:

INCREASE IN GOVERNMENT CONTRIBUTION RATE; REPEAL OF 75 PER CENTUM MAXIMUM

SEC. 2. (a) Section 8906(b)(1) of title 5, United States Code, relating to the Government contribution, is amended by striking out "60 percent" and inserting in lieu thereof "75 percent".

(b) Section 8906(b)(2) of title 5, United States Code, is amended by striking out "75 percent" and inserting in lieu thereof "100 percent".

(c) Section 8906(b) of title 5, United States Code, is amended by adding at the end thereof the following new paragraph:

"(4) In addition to the Government contribution, a Government differential shall be paid in the case of each employee or annuitant who is 65 years of age or older, who is not entitled to hospital insurance benefits under part A of title XVIII of the Social Security Act (42 U.S.C. 1395c and following), and who is enrolled in an approved health benefits plan. Such differential shall be equal to 5 percent of the average subscription charge determined under subsection (a) of this section. The Government differential under this paragraph shall be treated the same as the Government contribution except that—

"(A) such differential shall not be taken into account in determining the amount to be paid by the employee or annuitant; and

"(B) such differential shall be paid to the health benefits plan in which the employee or annuitant is enrolled.".

(d) The amendments made by this section shall become effective with respect to contracts entered into or renewed for calendar year 1984 or thereafter.

CONTINUATION OF COVERAGE FOR EMPLOYEES SEPARATED DUE TO A REDUCTION IN FORCE, AND CERTAIN OTHERS

SEC. 3. (a)(1) Chapter 89 of title 5, United States Code, is amended by adding after section 8906 the following new section:

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"§ 8906a. Continuation of coverage

"(a) An individual described in paragraph (1), (2), (3), or (4) of subsection (b) of this section may elect to continue coverage under an approved health benefits plan in accordance with the provisions of this section.

"(b)(1) An employee who is involuntarily separated from the civil service due to a reduction in force, and who was enrolled in an approved health benefits plan immediately before the separation, may continue such individual's enrollment for self alone or for self and family (as the case may be).

"(2) In the case of the spouse of an employee or annuitant whose marriage is dissolved by divorce or annulment, if the employee or annuitant was enrolled for self and family in an approved health benefits plan immediately before the divorce or annulment becomes final, the former spouse of such employee or annuitant may continue the enrollment for self and family or for self alone, except that nothing in this paragraph shall be construed to allow an unmarried dependent child to be enrolled as a member of more than one family at any time.

"(3) An individual who elects to receive the lump-sum credit under section 8342(a) of this title, and who was enrolled in an approved health benefits plan immediately before such election, may continue such individual's enrollment for self alone or for self and family (as the case may be).

"(4) An individual who is 22 years of age or older may continue such individual's enrollment in an approved health benefits plan if—

"(A) the enrollment being continued was based on such individual's being an unmarried dependent child who was incapable of self-support because of a mental or physical disability which existed before age 22; and

"(B) such disability is determined not to have ended before such individual attained age 22.

"(c)(1) Any individual seeking to continue enrollment in a health benefits plan under this section shall, within 31 days after the date of the terminating event, and in accordance with such procedures as the Office of Personnel Management shall by regulation prescribe, file an election to continue such enrollment and arrange to pay currently into the Employees Health Benefits Fund an amount equal to the sum of the employee and agency contributions payable in the case of an employee enrolled in the same health benefits plan and level of benefits.

"(2) The Office may, for good cause shown, extend the 31-day period referred to in paragraph (1) of this subsection.

"(3) For the purpose of paragraph (1) of this subsection, 'date of the terminating event' means—

"(A) in the case of an individual involuntarily separated from the civil service due to a reduction in force, the date as of which such individual is so separated;

"(B) in the case of the spouse of an employee or annuitant whose marriage is dissolved by divorce or annulment, the date that the divorce or annulment becomes final;

"(C) in the case of an individual who elects to receive the lump-sum credit under section 8342(a) of this title, the date that the payment of the lump-sum credit is made; and

"(D) in the case of an unmarried individual 22 years of age or older whose coverage is based on a mental or physical disability which existed before age 22, the date that such disability is determined under this chapter no longer to exist.

"(d)(1) An individual who makes an election under subsection (c) of this section may, at the time of making such election and under the conditions prescribed by regulations of the Office, change the level of benefits under the health benefits plan in which such individual is continuing coverage, but only if the change is to a lower level.

"(2) An individual enrolled in a health benefits plan under this section—

"(A) may change such individual's coverage or that of the individual and members of such individual's family (as the case may be) by an application filed within 60 days after a change in family status or at other times and under conditions prescribed by regulations of the Office; and

"(B) may transfer such individual's enrollment to another plan described by section 8903 of this title at the times and under the conditions prescribed by regulations of the Office.

"(3) An individual—

"(A) who is eligible to continue enrollment in a health benefits plan under this section, but who does not make an election under subsection (c) of this section, or

"(B) who makes an election under subsection (c) of this section, but whose enrollment is subsequently ended (other than by a cancellation of enrollment),

shall be granted a temporary extension of coverage, during which such individual may exercise the option to convert, without evidence of good health, to a nongroup contract providing health benefits. Any individual who exercises this option shall pay the full periodic charges of the nongroup contract.

"(e)(1) The coverage provided under this section for any individual separated due to a reduction in force (described in subsection (b)(1)) may not extend beyond the end of the 12th calendar month beginning after the separation takes effect, or (if earlier) the first day the individual involved becomes employed by any employer in a position in which the individual is eligible to participate in any health benefits plan that is sponsored (in whole or in part) by such employer and has benefits at least equivalent to the lowest benefit level available under any approved Government-wide plan.

"(2) Under regulations prescribed by the Office of Personnel Management, the coverage provided under this section for any other individual described in subsection (b) may not extend beyond the end of the calendar month during which the status or circumstances of the individual change to the extent that the individual ceases to meet the applicable requirements under paragraph (2), (3), or (4), as the case may be.".

(2) The analysis for chapter 89 of title 5, United States Code, is amended by inserting after the item relating to section 8906 the following new item:

"8906a. Continuation of coverage.".

(b) Section 8906(d) of title 5, United States Code, is amended—

(1) by striking out "(d)" and inserting in lieu thereof "(d)(1)"; and

(2) by adding at the end thereof the following new paragraph:

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"(2) Nothing in paragraph (1) of this subsection shall be construed to prohibit the enrollment of an annuitant whose annuity is less than the withholding required under such paragraph if such annuitant arranges to pay, at the times and under the conditions prescribed by the Office, the amount of the deficiency.".

(c) The amendments made by this section shall become effective with respect to contracts entered into or renewed for calendar year 1984 or thereafter.

FINANCIAL RESPONSIBILITY REQUIREMENT

SEC. 4. (a) Section 8902 of title 5, United States Code, relating to the contracting authority of the Office of Personnel Management, is amended by redesignating subsections (d) through (m) as subsections (e) through (n), respectively, and by inserting after subsection (c) the following new subsection:

"(d) A contract for a plan described by section 8903(3) of this title shall require the carrier—

"(1) to meet the reinsurance requirements of subsection (c)(1) of this section;

"(2) to enter into an agreement approved by the Office with an underwriting subcontractor licensed to issue group health insurance in all the States and the District of Columbia; or

"(3) to demonstrate ability to meet reasonable minimum financial standards prescribed by the Office.".

(b) Section 8902(i) of title 5, United States Code, as redesignated by subsection (a), is amended by striking out "under subsection (g)" and inserting in lieu thereof "under subsection (h)".

(c) The amendments made by this section shall become effective with respect to contracts entered into or renewed for calendar year 1986 or thereafter.

MENTAL HEALTH BENEFITS

SEC. 5. (a) The first sentence of section 8904 of title 5, United States Code, is amended by striking out "may" and inserting in lieu thereof "shall".

(b) Paragraphs (1) and (2) of section 8904 of title 5, United States Code, are amended by adding at the end of each such paragraph the following:

"(G) Nervous and mental disorder benefits.

"(H) Alcoholism and substance abuse treatment and rehabilitation benefits.".

(c) Section 8904 of title 5, United States Code, is amended by adding after paragraph (4) the following:

"(5) No health benefits plan described in paragraph (1), (2), or (3) of this section shall be contracted for or approved which does not provide, without discrimination as to the coinsurance ratio or the deductible, for 50 outpatient visits and 60 inpatient days of nervous and mental disorder benefits, and two 28-day alcoholism treatment and rehabilitation benefits, but such alcoholism benefits are only required to the extent that an individual has not previously been enrolled in a program of similar duration for which benefits were provided.

"(6) Whenever benefits of the type described in paragraph (1)(G) or (2)(G) of this section under any plan contracted for or approved hereunder are limited, such limits shall be exceeded on a case-by-case basis and only to the extent that an established peer review mechanism determines such treatment to be medically or psychologically necessary and appropriate.

"(7) The catastrophic benefits provided for in paragraph (6) of this section shall be paid out of the stop-loss fund established by section 8909(a)(3) of this title to the extent of 80 percent of the part of each outpatient claim that exceeds 50 visits annually and 80 percent of the part of each inpatient claim resulting from a period of hospitalization in excess of 60 days.".

(d) Section 8909(a) of title 5, United States Code, is amended—

(1) in paragraph (1), by striking out "and";

(2) in paragraph (2), by striking out the period and inserting in lieu thereof "; and"; and

(3) by adding at the end thereof the following:

"(3) to pay the catastrophic benefits described in paragraphs (6) and (7) of section 8904 of this title.".

(e) Section 8909(b)(1) of title 5, United States Code, is amended to read as follows:

"(1) One percent of all contributions made available by subsection (a) of this section out of which is to be allocated that part determined by the Office to be reasonably adequate to pay the administrative expenses referred to in subsection (a)(2) of this section with the balance to be used to pay the catastrophic benefits referred to in subsection (a)(3) of this section.".

(f) The first sentence following paragraph (2) in section 8909(b) of title 5, United States Code, is amended by inserting "expenses" after "and for catastrophic benefits".

(g) The amendments made by this section shall become effective with respect to contracts entered into or renewed for calendar year 1984 or thereafter.

COMPREHENSIVE DENTAL BENEFITS

SEC. 6. (a) Paragraphs (1) and (2) of section 8904 of title 5, United States Code, as amended by section 5, are further amended by adding at the end of each such paragraph the following:

"(I) Comprehensive dental benefits.".

(b) The amendments made by this section shall become effective with respect to contracts entered into or renewed for calendar year 1984 or thereafter.

LIMITATIONS ON BENEFIT REDUCTIONS AND OFFICE OF PERSONNEL MANAGEMENT CONTRACTING DISCRETION

SEC. 7. (a) Section 8902 of title 5, United States Code, relating to contracting authority, as amended by section 4, is amended by adding at the end thereof the following new subsection:

"(o)(1) Except as provided under paragraph (2) of this subsection, the Office may not negotiate or enter into any contract with any qualified carrier for any health benefits plan for any calendar year unless the benefits provided by such plan are actuarially equivalent to at least 95 percent of (A) the benefits under the plan provided by such carrier for the preceding calendar year, or (B) if the plan was not offered by any carrier during the preceding year, the benefits provided by the approved plan which was offered during the preceding year and which is most similar to the plan.

"(2) The requirements of paragraph (1) shall not apply if the carrier and the Office mutually agree to a waiver of such requirements.

"(3) The Office shall exercise its authority under subsection (a) and enter into a contract with any qualified carrier for any calendar year if—

"(A) the plan benefits meet the applicable requirements of paragraph (1), and

"(B) the carrier and the plan offered by the carrier under the contract meet all applicable standards and requirements established by and under this chapter.".

(b) The amendments made by this section shall become effective with respect to contracts entered into or renewed for calendar year 1984 or thereafter.

OPEN SEASON

SEC. 8. (a) Section 8905(e) of title 5, United States Code, is amended to read as follows:

"(e)(1) The Office shall prescribe regulations under which, before the start of any contract term in which an adjustment is to be made in any of the rates charged or benefits provided under a health benefits plan described by section 8903 of this title, or a newly approved health benefits plan is offered or an existing plan is terminated a period of not less than 3 weeks shall be provided during which any employee or annuitant enrolled in a health benefits plan described by that section may either transfer that individual's enrollment to another such plan or cancel such enrollment.

"(2) Not later than 4 weeks before the start of any period described in paragraph (1) of this subsection, the Office shall make available to each employee or annuitant enrolled in a health benefits plan under this chapter the information required by section 8907(a) of this title.".

(b) The amendments made by this section shall become effective with respect to contracts entered into or renewed for calendar year 1984 or thereafter.

EMPLOYEE STATUS

SEC. 9. (a) Section 8902(f) of title 5, United States Code, is amended by inserting "nonactive employee status," after "health status,".

(b) The amendment made by this section shall become effective with respect to contracts entered into or renewed for calendar year 1984 or thereafter.

ELIMINATION OF REQUIREMENT OF THREE MEDICAL SPECIALTIES FOR GROUP-PRACTICE PREPAYMENT PLANS

SEC. 10. (a) The second sentence of section 8903(4)(A) of title 5, United States Code, relating to group-practice prepayment plans, is amended to read as follows: "The group shall include physicians who receive all or a substantial part of their professional income from the prepaid funds and who represent medical specialties appropriate and necessary for the population served and proposed to be served by the plan.".

(b) The amendment made by this section shall become effective with respect to contracts entered into or renewed for calendar year 1984 or thereafter.

O

TRANSMITTAL SLIP | 3 JAN 1984

TO: DD/Pers/SP

STAT

ROOM NO.	BUILDING
6N20	[redacted]

REMARKS:

STAT

FROM: [redacted]

STAT

ROOM NO.	BUILDING	EXTENSION
7B24	HQS	[redacted]

FORM NO. 1 FEB 55 241 REPLACES FORM 36-8 WHICH MAY BE USED. (47)

9 JAN 1984

MEMORANDUM FOR: Deputy Director of Personnel for Special Programs

STAT

FROM: Liaison Division
Office of Legislative Liaison

SUBJECT: Senate Hearing on the Federal Employee Health Benefits Program (FEHBP)

1. Attached for your information and analysis are copies of prepared testimony presented at a recent Senate Committee on Governmental Affairs subcommittee hearing. The subcommittee with jurisdiction, chaired by Senator Ted Stevens (R., AK), plans to hold at least one more hearing on the Senate bills introduced to, in one way or another, amend the FEHBP. This hearing will in all likelihood not be held until early March, this because Senator Stevens' responsibilities in the Defense Appropriations arena will totally preoccupy his attention until then.

2. Senator Stevens' legislative assistant handling this matter at the subcommittee level advises that Senators Stevens and Durenberger (IR., MN) have tentatively agreed that the marked-up bill that comes out of the Governmental Affairs subcommittee will be the bill that Senator Durenberger introduced (S.1685) rather than the one introduced by Senator Stevens (S.2027). The two senators have tasked their respective staffs with identifying areas of the two bills (S.1685 and S.2027) where there is disagreement. These areas of disagreement will then be given to an unnamed office within the Government Accounting Office (GAO), which will be tasked with drafting a proposed, and compromise, markup of S.1685 for the two Senators' consideration.

3. The present legislative plan for an FEHBP bill anticipates subcommittee and full Governmental Affairs Committee markup in the mid-May 1984 timeframe, with the marked up S.1685 on the Senate calendar when the Senate returns from an anticipated Memorial Day recess, in early June 1984.

4. I will keep you advised of developments on this matter as they arise.

STAT

Attachments:
As stated

United States Senate

COMMITTEE ON
GOVERNMENTAL AFFAIRS

SUBCOMMITTEE ON
CIVIL SERVICE, POST OFFICE, AND
GENERAL SERVICES

WASHINGTON, D.C. 20510

Hearing on

FEDERAL EMPLOYEES HEALTH BENEFITS LEGISLATION

Thursday, December 1, 1983
Room SD-342

Morning Session - 10:00 a.m. to 12:00
Afternoon Session - 2:00 to 4:00 p.m.

WITNESS LIST

Morning

1. The Honorable Daniel K. Inouye
   United States Senate

2. The Honorable David Durenberger
   United States Senate

3. The Honorable Donald J. Devine
   Director
   Office of Personnel Management

4. Michael Zimmerman
   Associate Director
   Human Resources Division
   General Accounting Office
   accompanied by: Robert Iffert
   Health Care Financing Advisor
   and
   Stephen Backhus
   Area Manager

United States Senate

COMMITTEE ON
GOVERNMENTAL AFFAIRS

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WITNESS LIST

Afternoon

1. Maurice J. Twomey
Chairman
Employee Organization Federal Employees Health Benefits Program Association
accompanied by: Marcia J. McQuillen, Director
National Association of Government Employees Health Benefit Plan
and
Thomas J. Feeney, General Manager
Special Agents Mutual Benefit Association

2. PANEL:

The Honorable Wilbur Mills
Co-Chair, Public Policy Committee
National Council on Alcoholism

John J. McGrath, M.D.
Trustee
American Psychiatric Association

Martin H. Stein, M.D.
Medical Director, Dominion Psychiatric Treatment Center representing the National Association of Private Psychiatric Hospitals

Clarence J. Martin
Executive Director and General Counsel
Association for the Advancement of Psychology

Andrew P. Miller
Washington Representative
National Federation of Societies for Clinical Social Work, Inc.

Lawrence S. Sack, M.D.
President
Washington Psychiatric Society

TESTIMONY OF SENATOR DANIEL K. INOUYE BEFORE SUBCOMMITTEE ON CIVIL SERVICE, POST OFFICE, AND GENERAL SERVICES, REGARDING FEDERAL EMPLOYEES HEALTH BENEFITS LEGISLATION--THURSDAY, DECEMBER 1, 1983.

MR. CHAIRMAN:

I AM PLEASED TO TESTIFY TODAY ON BEHALF OF A NUMBER OF LEGISLATIVE PROPOSALS THAT I HAVE INTRODUCED THIS SESSION WHICH WOULD AMEND OUR FEDERAL EMPLOYEES HEALTH BENEFIT PROGRAMS TO ENSURE THAT FEDERAL EMPLOYEES AND THEIR FAMILIES WILL HAVE ACCESS TO QUALITY HEALTH CARE AT REASONABLE COSTS. THE ESSENCE OF MY TESTIMONY TODAY IS TWOFOLD.

FIRST, I FEEL THAT THE TIME HAS COME FOR US TO AFFIRMATIVELY AND EXPRESSLY RECOGNIZE IN THE FEDERAL EMPLOYEES HEALTH BENEFIT STATUTE THAT HEALTH CARE TODAY IS NO LONGER SOLELY THE PROVINCE OF ONE PROFESSION.

INSTEAD, IT SHOULD BE MADE CLEAR IN THE LAW THAT IT IS IN OUR NATIONAL INTEREST TO DIRECTLY RECOGNIZE AND PROVIDE FOR THE INDEPENDENT REIMBURSEMENT OF A NUMBER OF ALTERNATIVE HEALTH CARE PROVIDERS. IN PARTICULAR, I AM REFERRING TO OUR NATION'S CERTIFIED NURSE-MIDWIVES, NURSE PRACTITIONERS, PROFESSIONAL PSYCHOLOGISTS, AND CLINICAL SOCIAL WORKERS. BY DOING THIS, NOT ONLY WILL WE REDUCE INDIVIDUAL PROVIDER COSTS, BUT MORE IMPORTANTLY, IN MY JUDGMENT, WE WILL ACTIVELY ENCOURAGE THESE ALTERNATIVE HEALTH CARE PROVIDERS TO DELIVER SERVICES THAT YOU AND I, AS LAYPERSONS, WOULD CONSIDER AS "BEHAVIORAL HEALTH", "WELLNESS", OR "PREVENTIVE CARE".

THIS IS THE TYPE OF NON-CURATIVE CARE THAT, AT THE FUNDAMENTAL PUBLIC POLICY LEVEL, WE MUST ACTIVELY FOSTER IF WE ARE EVER TO CURTAIL THE EVER-ESCALATING COSTS OF HEALTH CARE. IT IS ONLY BY DOING THIS THAT WE WILL EVER EFFECTIVELY ADOPT THE RECOMMENDATIONS INHERENT IN THE SURGEON GENERAL'S REPORT HEALTHY PEOPLE AND THE INSTITUTE OF MEDICINE'S SUBSEQUENT REPORT HEALTH AND BEHAVIOR: FRONTIERS IN THE BIOBEHAVIORAL SCIENCES. BOTH OF THESE DOCUMENTS HAVE HIGHLIGHTED, FOR EXAMPLE, THAT: "AS MUCH AS 50 PERCENT OF MORTALITY FROM THE 10 LEADING CAUSES OF DEATH IN THE UNITED STATES CAN BE TRACED TO LIFESTYLE".

MY SECOND MAJOR POINT IS THAT WE MUST FACE UP TO THE REALITY THAT THERE STILL EXISTS IN OUR SOCIETY AN UNFORTUNATE STIGMA ASSOCIATED WITH MENTAL HEALTH TREATMENT. HISTORICALLY, OUR SOCIETY HAS BEEN UNWILLING TO ACCORD PARITY BETWEEN MENTAL HEALTH BENEFITS AND OTHER PHYSICAL HEALTH CARE BENEFITS. ADMITTEDLY, THIS IS IN NO SMALL PART ALSO THE RESULT OF THE INABILITY OF COLLECTIVE UNWILLINGNESS OF THE VARIOUS MENTAL HEALTH DISCIPLINES TO COME TO BASIC AGREEMENT AS TO WHAT SHOULD BE CONSIDERED APPROPRIATE CARE AND WHAT SHOULD BE THE APPROPRIATE SCOPE OF PRACTICE OF EACH DISCIPLINE.

MR. CHAIRMAN, IN MY JUDGMENT, THE DEPARTMENT OF DEFENSE APPROPRIATIONS SUBCOMMITTEE, WHICH YOU ALSO CHAIR, HAS DONE AN EXCELLENT JOB OF ADDRESSING THESE TWO COMPLEX ISSUES UNDER THE CHAMPUS PROGRAM, AND I HOPE THAT YOU WILL NOW BE WILLING TO RECOMMEND MODIFICATIONS OF THE FEDERAL EMPLOYEES HEALTH BENEFIT STATUTE BASED UPON OUR CHAMPUS EXPERIENCES.

MR. CHAIRMAN, PRESENTLY, UNDER BOTH THE DEPARTMENT OF DEFENSE CHAMPUS PROGRAM AND UNDER THE FEDERAL MEDICAID STATUTE, THE CONGRESS OF THE UNITED STATES HAS EXPRESSLY STATED THAT INDIVIDUAL BENEFICIARIES SHALL HAVE ACCESS TO THE SERVICES OF CERTIFIED NURSE-MIDWIVES,

WHETHER OR NOT THERE IS PHYSICIAN (OR OTHER HEALTH CARE PROVIDER) INVOLVEMENT, AS LONG AS THESE SERVICES ARE AUTHORIZED BY STATE LAW. IN JUNE OF 1982, THE GENERAL ACCOUNTING OFFICE (GAO), AT MY REQUEST, CONDUCTED A REVIEW OF THE AVAILABILITY OF NURSE-MIDWIFE SERVICES UNDER THE VARIOUS FEDERAL HEALTH CARE PROGRAMS. THE GAO REPORTED THAT APPROXIMATELY 91 PERCENT OF ALL FEDERAL EMPLOYEES ARE ENROLLED IN HEALTH INSURANCE PLANS OFFERING THESE BENEFITS EVEN THOUGH ONLY ABOUT 31 PERCENT OF THE FEDERAL EMPLOYEES HEALTH BENEFIT PLANS PROVIDED NURSE-MIDWIFE COVERAGE. I AM NOW SUBMITTING A COPY OF THIS REPORT FOR YOUR RECORD.

DURING OUR DELIBERATIONS ON THE FISCAL YEAR 1982 URGENT SUPPLEMENTAL APPROPRIATIONS BILL, PUBLIC LAW 97-216, THE APPROPRIATIONS COMMITTEE INCLUDED REPORT LANGUAGE, WHICH YOU AND I DISCUSSED DURING THE "MARKUP", DIRECTING THE OFFICE OF PERSONNEL MANAGEMENT (OPM) TO COLLECT APPROPRIATE DATA AND REPORT BACK TO OUR COMMITTEE ON ITS EFFORTS TO INCREASE UTILIZATION OF CERTIFIED NURSE-MIDWIVES. WE DID THIS PRIMARILY FOR TWO REASONS: FIRST, WE HAVE SEEN NO OBJECTIVE EVIDENCE TO SUGGEST THAT CERTIFIED NURSE-MIDWIVES PROVIDE ANYTHING BUT THE HIGHEST QUALITY CARE.

SECONDLY, BECAUSE THERE IS GROWING EVIDENCE THAT BY USING THESE PRACTITIONERS RATHER THAN THE TRADITIONAL MEDICAL SYSTEM, THAT OVERALL SAVINGS OF FROM 33 TO 66 PERCENT OF BIRTHING COSTS MAY BE OBTAINED.

MR. CHAIRMAN, THE OFFICE OF PERSONNEL MANAGEMENT IS NOW BEGINNING TO COLLECT NURSE-MIDWIFERY DATA, AS WELL AS DATA ON OTHER NON-PHYSICIAN PRACTITIONERS AS A RESULT OF PUBLIC LAW 96-179, WHICH PROVIDED FOR A SPECIAL DEMONSTRATION PROJECT IN WHICH ALL LICENSED CERTIFIED PRACTITIONERS, IN CERTAIN MEDICALLY-UNDERSERVED AREAS, WOULD BE ABLE TO BE DIRECTLY REIMBURSED IF THE SERVICE ITSELF WERE REIMBURSABLE.

NEVERTHELESS, AS A PRACTICAL MATTER, I FEEL THAT IN THE CASE OF CERTIFIED NURSE-MIDWIVES, THERE REALLY IS NO NEED TO AWAIT ANY FURTHER DATA COLLECTION ANALYSIS. UNDER CHAMPUS AND A NUMBER OF PRIVATE AND STATE MEDICAID PROGRAMS, CERTIFIED NURSE-MIDWIVES HAVE ALREADY DEMONSTRATED THAT THEIR CARE IS TRULY COST-EFFECTIVE. WE HAVE NO EVIDENCE, UNDER CHAMPUS FOR EXAMPLE, OF ANY INCIDENT OF LOWER QUALITY CARE. AND, I MIGHT ADD THAT CHAMPUS HAS BEEN DIRECTLY REIMBURSING CERTIFIED NURSE-MIDWIVES SINCE OCTOBER 1978.

UNDER THE PRESENT FEDERAL EMPLOYEES HEALTH BENEFIT PROGRAM, THERE IS A PROVISION IN THE LAW (SECTION 8902, SUBSECTION K) WHICH STATES THAT FOR THE CASE OF OPTOMETRISTS AND PSYCHOLOGISTS, IF THE SERVICE IS TO BE PROVIDED BY THE PLAN, THAT BENEFICIARIES WILL HAVE DIRECT ACCESS TO THESE PRACTITIONERS IF THEY SO DESIRE. MR. CHAIRMAN, I RECOMMEND THAT YOUR COMMITTEE NOW ALSO INCLUDE CERTIFIED NURSE-MIDWIVES AND NURSE PRACTITIONERS IN THIS PROVISION BASED UPON OUR CHAMPUS EXPERIENCES. I WOULD ALSO, AT THIS TIME, REQUEST THAT ADDITIONAL TESTIMONY PREPARED BY THE AMERICAN COLLEGE OF NURSE-MIDWIVES BE INCLUDED IN YOUR RECORD AS AN APPENDIX TO MY TESTIMONY.

MR. CHAIRMAN, I WOULD NOW LIKE TO VERY BRIEFLY DISCUSS THE MENTAL HEALTH PROVISIONS WHICH YOU ARE CONSIDERING. FIRST, GIVEN THE UNFORTUNATE STIGMA ATTACHED TO MENTAL HEALTH CARE, I FEEL THAT IT IS IMPORTANT FOR THE CONGRESS TO ACT TO ENSURE THAT A REASONABLE MENTAL HEALTH BENEFIT BE INCLUDED IN THE VARIOUS FEDERAL EMPLOYEE HEALTH BENEFIT PLANS. I DO NOT FEEL THAT THIS PROVISION SHOULD BE LEFT SOLELY TO THE DISCRETION OF THE OFFICE OF PERSONNEL MANAGEMENT. ACCORDINGLY, I WAS ESPECIALLY PLEASED TO NOTE YOUR EFFORTS TO ENSURE THAT FORMER FEDERAL EMPLOYEE MEDICARE BENEFICIARIES WILL BE ABLE TO PURCHASE SUPPLEMENTAL MENTAL HEALTH BENEFITS.

I WOULD ALSO SUGGEST THAT BY STATUTE, WE MAKE EXPRESSLY CLEAR THAT MENTAL HEALTH CARE IS TRULY INTERDISCIPLINARY IN NATURE. OUR NATION'S PSYCHIATRIC NURSES AND CLINICAL SOCIAL WORKERS SHOULD BE EXPRESSLY AUTHORIZED TO BE DIRECTLY REIMBURSED WHEREVER THEIR SERVICES HAVE BEEN DULY RECOGNIZED BY OUR VARIOUS STATE LEGISLATURES. AGAIN, WE HAVE DONE THIS UNDER CHAMPUS WITH EXCELLENT RESULTS. I ALSO HAVE BEEN MOST IMPRESSED BY THE POTENTIAL OF INTERDISCIPLINARY PEER REVIEW TO ENSURE NOT ONLY THAT QUALITY MENTAL HEALTH CARE WILL BE PROVIDED, BUT ALSO THAT PROFESSIONS CAN ASSURE US THAT THERE WILL NO LONGER CONTINUE TO BE EXCESSIVE RELIANCE ON VERY EXPENSIVE INPATIENT MENTAL HEALTH CARE.

AS YOU ARE AWARE, TRADITIONALLY NEARLY 80 PERCENT OF THE CHAMPUS MENTAL HEALTH BUDGET HAS BEEN ON INPATIENT CARE, THE COST OF WHICH CONTINUES TO ESCALATE BEYOND BELIEF.

PEER REVIEW IS NOT INEXPENSIVE. THE CHAMPUS COST PER REVIEW RANGES FROM $156.00 TO $268.00; HOWEVER, I FEEL THAT IT IS AN EXCELLENT EXPENDITURE AND, IN FACT, WAS PLEASED THAT OUR APPROPRIATIONS COMMITTEE HAS NOW DIRECTED CHAMPUS TO BEGIN IMPLEMENTING A PEER REVIEW APPROACH WITH SURGICAL CARE. MR. CHAIRMAN, I WOULD NOW LIKE TO SUBMIT FOR YOUR RECORD VARIOUS BACKGROUND MATERIALS FROM THE DEPARTMENT OF DEFENSE CHAMPUS PROGRAM.

TESTIMONY

BY

SENATOR DAVE DURENBERGER

BEFORE

THE SUBCOMMITTEE ON CIVIL SERVICE

REGARDING

THE FEDERAL EMPLOYEES HEALTH BENEFITS PLAN

DECEMBER 1, 1983

MR. CHAIRMAN, LET ME FIRST COMMEND YOU FOR SCHEDULING THIS HEARING. OVER THE PAST SEVERAL YEARS, YOU HAVE SHOWN SPECIAL CONCERN FOR THE PROBLEMS THAT HAVE SURFACED IN THE FEHBP. YOU HAVE BEEN INSTRUMENTAL IN BRINGING CONCERNED PARTIES TOGETHER AND FORMULATING SOLUTIONS. I LOOK FORWARD TO WORKING WITH YOU AND OTHER MEMBERS OF THE GOVERNMENTAL AFFAIRS COMMITTEE IN REACHING A CONSENSUS ON FEHBP REFORM LEGISLATION.

THE HEARING IS TIMELY BECAUSE IT COMES IN THE MIDST OF OUR FALL OPEN SEASON. IN THE LAST FEW WEEKS THERE HAS BEEN MORE DISCUSSION, MORE PUBLICITY, MORE ADVERTISING, AND MORE CHOICE THAN IN ANY OPEN SEASON I CAN RECALL. IT SERVES TO EMPHASIZE THE VALUE OF MULTIPLE HEALTH PLAN CHOICE TO

INDIVIDUALS. THE PRICE, BENEFIT, AND DELIVERY SYSTEM ALTERNATIVES GIVE INDIVIDUALS THE OPPORTUNITY TO BETTER MATCH A HEALTH PLAN WITH THEIR NEEDS. AND THE COMPETITION AMONG HEALTH PLANS FOSTERS COST CONTAINMENT--AND THAT BENEFITS EVERYONE.

AS CHAIRMAN OF THE FINANCE COMMITTEE'S HEALTH SUBCOMMITTEE, I'VE DEVELOPED A STRONG INTEREST IN HEALTH FINANCING ISSUES. ALTHOUGH HEALTH FINANCING ISSUES MAY NOT HAVE THE PIZAZZ OF CANCER RESEARCH OR HERPES CURES, HEALTH FINANCING LAYS THE FOUNDATION FOR OUR HEALTH CARE SYSTEM. THE DECISIONS GOVERNMENT MAKES WITH RESPECT TO FINANCING HEALTH CARE FOR BOTH EMPLOYEES AND BENEFICIARIES ULTIMATELY DETERMINES THE EFFICIENCY WITH WHICH SERVICES ARE DELIVERED TO PATIENTS ALL OVER THE COUNTRY.

AS YOU KNOW, MR. CHAIRMAN, I HAVE INTRODUCED MY OWN LEGISLATION--S. 1685--TO REFORM THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM. I WOULD LIKE TO USE MY TIME THIS MORNING TO BOTH COMMENT SPECIFICALLY ON THAT LEGISLATION AND DISCUSS MORE GENERALLY THE HEALTH FINANCING ISSUES WE FACE IN THE FEHBP.

I THINK IT'S USEFUL TO START BY RECOGNIZING THAT OUR HEALTH CARE SYSTEM IS IN THE MIDST OF A REVOLUTION. IT IS A

REVOLUTION DRIVEN BY COST. FOR THE FIRST TIME, BUYERS OF HEALTH SERVICES ARE BECOMING SENSITIVE TO PRICE, AND ARE DIRECTING THEIR BUSINESS TO THOSE HEALTH CARE PROVIDERS THAT OFFER THE BEST CARE AT THE BEST PRICE.

THE REVOLUTION MARKS A MAJOR DEPARTURE FROM POLICIES THAT HAVE DEVELOPED OVER THE LAST 40 YEARS. IT WAS IN THE 1940S THAT EMPLOYERS STARTED OFFERING HEALTH INSURANCE COVERAGE ON A WIDESPREAD BASIS TO THEIR EMPLOYEES. IN 1954, THE TAX BREAK WE PROVIDED FOR EMPLOYER-BASED HEALTH COVERAGE FURTHER SPURRED GROWTH. IN 1965, THE ENACTMENT OF THE MEDICARE AND MEDICAID PROGRAMS FILLED THE MAJOR GAPS LEFT BY PRIVATE INSURANCE. BY EARLY THIS YEAR, 87 PERCENT OF OUR CITIZENS WERE COVERED BY SOME FORM OF PRIVATE OR PUBLIC HEALTH INSURANCE. THE GROWTH OF THESE PROGRAMS HAS BEEN A TREMENDOUS BENEFIT FOR OUR CITIZENS. BUT IN THE COURSE OF DESIGNING THESE HEALTH INSURANCE PROGRAMS, WE ADOPTED SEVERAL FEATURES THAT MADE IT VIRTUALLY IMPOSSIBLE TO CONTAIN COSTS.

FIRST, WE DESIGNED INSURANCE PLANS THAT PROVIDED FIRST-DOLLAR COVERAGE. THAT IS, THE INSURANCE PLANS COVERED ALL EXPENSES, STARTING FROM THE FIRST DOLLAR OF SERVICES INCURRED.

SECOND, WE DESIGNED OUR HEALTH INSURANCE COVERAGE SO THAT A SINGLE INSURANCE PLAN COVERED THE ENTIRE ELIGIBLE POPULATION. THUS, AN EMPLOYER OFTEN CONTRACTED ONLY WITH BLUE CROSS OR AETNA OR PRUDENTIAL TO COVER ITS ENTIRE EMPLOYEE POPULATION. FURTHERMORE, BECAUSE OF THE TAX TREATMENT GIVEN EMPLOYER-PROVIDED FRINGE BENEFITS, EMPLOYERS WERE INCLINED TO PAY THE ENTIRE COST OF COVERAGE FOR THEIR EMPLOYEES.

AS A PUBLIC INSURER, THE FEDERAL GOVERNMENT WASN'T MUCH BETTER. THE MEDICARE PROGRAM IS DESIGNED AS A SINGLE, GOVERNMENT-RUN INSURANCE COMPANY. ONE POLICY COVERS ALL BENEFICIARIES.

THESE DEVELOPMENTS WERE BAD FOR SEVERAL REASONS. FOR ONE THING, EMPLOYER-PAID PREMIUMS AND FIRST-DOLLAR COVERAGE INSULATED THE INDIVIDUAL EMPLOYEE FROM THE COST OF CARE. WITHOUT A FINANCIAL INCENTIVE FOR THE EMPLOYEE TO EXAMINE THE NEED FOR AND COST OF SERVICES, BOTH DEMAND FOR SERVICES AND THEIR PRICES INCREASED.

FURTHERMORE, THE FACT THAT A SINGLE INSURANCE PLAN WAS OFFERED TO COVER ALL EMPLOYEES OR BENEFICIARIES GAVE HEALTH PROVIDERS VERY LITTLE INCENTIVE TO COMPETE OVER PRICE. IF A PHYSICIAN KEPT HIS OR HER PATIENTS HEALTHY AND OUT OF THE

HOSPITAL, THE PHYSICIAN RECEIVED NO REWARD. THAT PHYSICIAN'S GOOD HABITS SIMPLY HELPED HOLD THE OVERALL COSTS OF THE PLAN DOWN. IT CERTAINLY DIDN'T BRING ANY ADDITIONAL BUSINESS TO THE PHYSICIAN. A SINGLE COMPANY-WIDE INSURANCE PLAN PROVIDED THE PHYSICIAN WITH NO MEANS OF SEPARATING HIS OR HER EXPERIENCE FROM THE REST OF THE MEDICAL PROVIDER COMMUNITY.

AS AN EMPLOYER, THE FEDERAL GOVERNMENT WAS QUICKER THAN MOST TO RECOGNIZE THESE MISTAKES. WHEN THE FEDERAL EMPLOYEES HEALTH BENEFITS PLAN WAS FIRST ENACTED OVER 20 YEARS AGO, IT ESTABLISHED A SYSTEM BASED ON MULTIPLE CHOICE OF HEALTH PLANS AND EMPLOYEE SHARING OF COSTS.

I'M QUITE PLEASED THAT THESE FUNDAMENTAL FEATURES REMAIN CENTRAL TO THE FEDERAL EMPLOYEES HEALTH BENEFITS PLAN. PRIVATE EMPLOYERS AND THE MEDICARE PROGRAM HAVE ONLY RECENTLY RECOGNIZED THE IMPORTANCE OF THESE FEATURES, AND THEY ARE NOW BEING ADOPTED ALL ACROSS THE COUNTRY.

BEGINNING EARLY NEXT YEAR, MEDICARE BENEFICIARIES WILL, FOR THE FIRST TIME, HAVE THE OPTION OF USING THEIR ENTITLEMENT TO PURCHASE COVERAGE IN THE PRIVATE SECTOR. THE PRIVATE HEALTH PLAN THAT DOES THE BEST JOB OF KEEPING PATIENTS HEALTHY AND OUT OF THE HOSPITAL, THAT KEEPS COSTS

DOWN, AND THAT SUBSTITUTES THE RIGHT SERVICE AT THE RIGHT PRICE--THESE PLANS WILL BE VERY SUCCESSFUL IN ENROLLING MEDICARE BENEFICIARIES. IT'S AN APPROACH MODELED AFTER THE FEHBP.

MULTIPLE CHOICE AND EMPLOYEE COST SHARING--THESE ARE THE PRINCIPLES THAT FORM THE BASIS OF A HEALTH CARE MARKETPLACE. AND THEY ARE THE VERY PRINCIPLES THAT ARE FEEDING THE CURRENT HEALTH CARE REVOLUTION. THEY ARE PRINCIPLES THAT MUST NOT ONLY BE MAINTAINED IN THE FEHBP BUT STRENGTHENED.

INCREASED PATIENT CHOICE AND INCREASED PATIENT COST-SHARING DO NOT COME WITHOUT SOME PROBLEMS--PROBLEMS THAT MUST BE RESOLVED FOR THE SYSTEM TO RUN SMOOTHLY. AS EVIDENCE, RECALL WHAT HAPPENED TO THE FEHBP TWO YEARS AGO. FOR OVER 20 YEARS A MODEL OF CONSUMER CHOICE IN HEALTH CARE, THE FEHBP BROKE DOWN. FEDERAL EMPLOYEES SAW THEIR PREMIUMS RISE, THEIR BENEFITS FALL, AND THEIR CHOICE OF PLANS TEMPORARILY TAKEN AWAY. ONE OF THE LARGEST HEALTH PLANS IN THE FEHBP THREATENED TO WITHDRAW, AND SEVERAL UNIONS TOOK THE OFFICE OF PERSONNEL MANAGEMENT TO COURT.

THE PROBLEMS THAT CAUSED THIS BREAKDOWN--MOST IMPORTANTLY ADVERSE SELECTION AND THE LACK OF FINANCIAL PREDICTABILITY--ARE STILL WITH US TODAY. OUR REPRIEVE IS

TEMPORARY AT BEST. UNLESS THESE DEFICIENCIES ARE CORRECTED, WE WILL UNDOUBTEDLY EXPERIENCE A RECURRENCE OF THE DISRUPTION THAT OCCURRED IN 1981.

THE MOST SERIOUS PROBLEM FACING THE FEHBP IS ADVERSE SELECTION. ADVERSE SELECTION OCCURS ANYTIME A CHOICE OF HEALTH PLANS IS OFFERED TO EMPLOYEES. ADVERSE SELECTION OCCURS IN THE FEHBP, IT OCCURS WITH PRIVATE EMPLOYERS, AND IT WILL OCCUR IN THE VOLUNTARY VOUCHER PLAN TO BE OFFERED BY MEDICARE NEXT YEAR.

ADVERSE SELECTION DESCRIBES A SITUATION WHERE THE HEALTH RISKS IN AN ELIGIBLE POPULATION--IN THIS CASE FEDERAL WORKERS AND RETIREES--ARE NOT SPREAD EVENLY AMONG THE PARTICIPATING HEALTH PLANS. THE DIFFERENCES IN BENEFITS, PARTICIPATING PHYSICIANS, AND PRICES AMONG THE PLANS CREATE INCENTIVES FOR OLDER AND LESS HEALTHY INDIVIDUALS TO MIGRATE TO CERTAIN PLANS, WHILE YOUNGER, HEALTHIER FEDERAL WORKERS JOIN OTHERS. BECAUSE HEALTH PLAN PREMIUMS ARE BASED ON THE EXPERIENCE OF THE ENROLLED GROUP, THIS KIND OF MARKET SEGMENTATION DRIVES THE PREMIUMS OF CERTAIN PLANS HIGHER AND HIGHER. HEALTH PLAN PREMIUMS END UP REFLECTING NOT THE EFFICIENCY OF THE PLAN, BUT WHO IT ENROLLS.

IN THE CASE OF THE FEHBP, ADVERSE SELECTION IS WELL

DOCUMENTED. IN 1983, ANNUITANTS AS A PERCENTAGE OF TOTAL PLAN CONTRACTS RANGED FROM A HIGH OF 56 PERCENT, IN AETNA, TO A LOW OF 6 PERCENT, IN THE MAIL HANDLERS PLAN. MORE ANNUITANTS MEAN HIGHER COSTS, AND THAT MEANS RELATIVELY HIGHER PREMIUMS.

ADVERSE SELECTION DISTORTS PRICE SIGNALS AND UNDERMINES THE VERY PURPOSE OF INSURANCE, WHICH IS TO SPREAD RISK. HEALTH PLAN PREMIUMS SHOULD REFLECT THE EFFICIENCY OF THE PLAN, NOT THE RELATIVE RISK OF ITS ENROLLEES.

ADVERSE SELECTION IN A MULTIPLE CHOICE SETTING CAN NEVER BE FULLY CORRECTED. BUT THERE ARE STEPS THAT CAN BE TAKEN TO SUBSTANTIALLY DECREASE THE IMPACT OF ADVERSE SELECTION. FIRST, MINIMUM BENEFITS SHOULD BE ESTABLISHED AND APPLIED TO ALL PLANS. THE LESS VARIANCE THERE IS IN BENEFITS, THE LESS LIKELY IT IS THAT ENROLLEES WILL SELECT A HEALTH PLAN BASED ON ITS HIGHER OR LOWER BENEFITS AND THAT MEANS LESS ADVERSE SELECTION.

SECOND, ADVERSE SELECTION CAN BE REDUCED BY APPLYING EQUAL ENROLLMENT AND MARKETING REQUIREMENTS TO ALL PARTICIPATING PLANS. FOR EXAMPLE, ALL PLANS SHOULD BE REQUIRED TO ENROLL ANY INDIVIDUAL WHO CHOOSES THAT PLAN. IN THE FEHBP, FOR EXAMPLE, PLANS SHOULD NOT BE ALLOWED TO

DISCRIMINATE AGAINST ANNUITANTS. SOME EMPLOYEE ORGANIZATION PLANS ONLY ALLOW ANNUITANT MEMBERS TO ENROLL, EVEN THOUGH ACTIVE NON-MEMBERS ARE ENCOURAGED TO JOIN. FURTHERMORE, PLANS SHOULD NOT BE ALLOWED TO TARGET THEIR MARKETING AT LOW-RISK GROUPS. MARKETING MUST BE MONITORED TO ASSURE THAT IT IS DIRECTED AT THE ENTIRE ELIGIBLE POPULATION.

THIRD, EMPLOYER CONTRIBUTIONS TO HEALTH PLANS CAN BE ADJUSTED TO ACCOUNT FOR THE RELATIVE RISK OF EACH ENROLLEE. IN THE FEHBP, FOR EXAMPLE, FEDERAL RETIREES HAVE GREATER HEALTH NEEDS THAN ACTIVE EMPLOYEES. HEALTH PLANS THAT ENROLL MORE ANNUITANTS SHOULD RECEIVE A RELATIVELY HIGHER GOVERNMENT CONTRIBUTION. IN S. 1685 I PROPOSE THAT AN ADJUSTMENT IN THE GOVERNMENT CONTRIBUTION TO HEALTH PLANS SHOULD BE BASED ON ANNUITANT STATUS, AS WELL AS OTHER FACTORS THAT PREDICT COST--LIKE AGE, SEX, AND PLACE OF RESIDENCE.

THE ADJUSTMENTS THAT I PROPOSE WILL NOT BE EVIDENT TO ENROLLEES. ACTIVE EMPLOYEES AND ANNUITANTS, MALES AND FEMALES, 20-YEAR-OLDS AND 55-YEAR-OLDS WILL ALL PAY THE SAME AMOUNT OUT-OF-POCKET FOR JOINING THE SAME HEALTH PLAN. ONLY THE GOVERNMENT'S CONTRIBUTION TO THE HEALTH PLAN WILL VARY DEPENDING ON THESE FACTORS.

AS AN EXAMPLE, ASSUME THE FEDERAL GOVERNMENT ANNOUNCES A CONTRIBUTION FOR INDIVIDUALS COVERAGE OF $50 A MONTH. TWO HEALTH PLANS, HEALTH PLAN A AND HEALTH PLAN B ESTIMATE THEIR TOTAL COSTS FOR PROVIDING COVERAGE TO FEDERAL EMPLOYEES AT $75 A MONTH AND $80 A MONTH, RESPECTIVELY. HEALTH PLAN A DETERMINES THAT ITS FEDERAL ENROLLEES WILL COMPRISE A REPRESENTATIVE CROSS SECTION OF ACTIVE EMPLOYEES, ANNUITANTS, AND SO ON.

THE GOVERNMENT'S ACTUAL CONTRIBUTION TO THE PLAN WILL VARY DEPENDING ON THE ACTUARIAL FACTORS MENTIONED. THUS, THE GOVERNMENT CONTRIBUTION FOR A YOUNG, ACTIVE EMPLOYEE MIGHT BE $40 A MONTH, AND FOR AN OLDER ANNUITANT, IT MIGHT BE $60 A MONTH. BUT BY ENROLLING A REPRESENTATIVE CROSS-SECTION OF GOVERNMENT EMPLOYEES AND ANNUITANTS, THE ACTUAL GOVERNMENT CONTRIBUTION WILL AVERAGE OUT TO $50 A MONTH. IN ORDER TO COVER ITS COSTS, PLAN A QUOTES A TOTAL PREMIUM OF $75 A MONTH AND RECEIVES $25 A MONTH FROM EACH OF ITS ENROLLEES.

PLAN B, ON THE OTHER HAND, EXPECTS THAT IT WILL ENROLL A POPULATION MADE UP LARGELY OF OLDER, RETIRED EMPLOYEES. BECAUSE OF THE ADJUSTMENTS IN THE GOVERNMENT CONTRIBUTION, PLAN B FIGURES TO RECEIVE A GOVERNMENT CONTRIBUTION FOR ITS ENROLLEES THAT AVERAGES $60 A MONTH. TO COVER ITS TOTAL

COST OF $80 A MONTH, PLAN B NEEDS A $20 A MONTH CONTRIBUTION FROM EACH ENROLLEE. SINCE ALL FEDERAL EMPLOYEES AND ANNUITANTS ARE TOLD THAT THE GOVERNMENT CONTRIBUTION IS $50 A MONTH, PLAN B MUST QUOTE A TOTAL PREMIUM OF ONLY $70 A MONTH TO RECEIVE THE $20 IT NEEDS.

THE RESULT OF THE PROPOSED ADJUSTMENT IN THE GOVERNMENT CONTRIBUTION IS THAT PLANS WITH RELATIVELY MORE YOUNG, HEALTHY ENROLLEES WILL HAVE TO QUOTE A HIGHER PREMIUM, AND PLANS WITH OLDER ENROLLEES WILL BE ABLE TO QUOTE A RELATIVELY LOWER PREMIUM. PLAN PREMIUMS WILL MORE ACCURATELY REFLECT THE EFFICIENCY OF THE PLAN RATHER THAN ITS ABILITY TO ATTRACT GOOD RISKS.

YOU CAN EXPECT THAT MY PROPOSAL TO ADJUST THE GOVERNMENT CONTRIBUTION WILL BE VIEWED FAVORABLY BY PLANS THAT HAVE BEEN SELECTED AGAINST AND UNFAVORABLY BY THOSE PLANS THAT HAVE BEEN ABLE TO ATTRACT YOUNG, HEALTHY ENROLLEES. THEY ARE EACH LOOKING OUT FOR THEIR OWN SPECIAL INTERESTS. I SHOULD POINT OUT, HOWEVER, THAT THIS KIND OF CORRECTION IS VITALLY IMPORTANT. IT IS IMPORTANT NOT ONLY TO THE FEDERAL EMPLOYEES HEALTH BENEFITS PLAN, BUT ALSO TO THE PRIVATE SECTOR. PRIVATE EMPLOYERS ARE STRUGGLING JUST AS HARD AS WE ARE TO FIND A WAY TO ADJUST FOR ADVERSE SELECTION. WE CAN SHOW THEM THE WAY. THE ADJUSTMENT APPROACH THAT I PROPOSE

HAS ALREADY BEEN ADOPTED IN THE MEDICARE VOLUNTARY VOUCHER PROVISION, AND IT SHOULD BE ADOPTED IN THE PRIVATE SECTOR AS WELL.

IGNORING ADVERSE SELECTION WILL NOT MAKE IT GO AWAY. AND UNLESS CORRECTIONS ARE ADOPTED, ADVERSE SELECTION THREATENS TO UNDO THE COMPETITIVE MARKETPLACE WE HAVE WORKED SO HARD TO ESTABLISH.

SWITCHING TO ANOTHER TOPIC, MULTIPLE CHOICE OF HEALTH PLANS RELIES ON INDIVIDUALS MAKING MAKE INFORMED DECISIONS. PROVIDING INDIVIDUALS WITH INFORMATION IS ONE OF THE PRIMARY RESPONSIBILITIES OF EMPLOYERS AND THE FEDERAL GOVERNMENT. WE MUST ACT AS THE BROKERS OF BASIC INFORMATION. THE FEDERAL GOVERNMENT DOES NOT NEED TO FEEL RESPONSIBLE FOR PROVIDING INDIVIDUALS WITH ALL THE INFORMATION THEY NEED,. BUT IT MUST PROVIDE THEM WITH THE BASIC INFORMATION--INFORMATION THAT CAN THEN BE SUPPLEMENTED BY EACH PLAN'S MARKETING AND BY RESOURCES IN THE PRIVATE SECTOR.

THE CURRENT SYSTEM FOR PROVIDING INFORMATION ON HEALTH CARE PLANS IN THE FEHBP MUST BE IMPROVED. SPECIAL ATTENTION MUST BE GIVEN TO MAKING THIS INFORMATION EASY TO ANALYZE. OPM IS TO BE COMMENDED FOR THE IMPROVEMENTS THEY HAVE MADE

IN COMPARATIVE INFORMATION OVER THE PAST SEVERAL YEARS. MORE WORK, HOWEVER, REMAINS TO BE DONE.

THE MERCER STUDY THAT WAS COMMISSIONED LAST YEAR BY THE HOUSE COMMITTEE ON POST OFFICE AND CIVIL SERVICE TO ANALYZE THE PROBLEMS IN THE FEDERAL EMPLOYEES PLAN DOCUMENTED THE VAST DIFFERENCES IN VALUE FROM ONE HEALTH PLAN TO ANOTHER. THESE DIFFERENCES IN VALUE ARE VERY HARD FOR EMPLOYEES AND ANNUITANTS TO JUDGE. THAT'S BECAUSE IT'S VERY DIFFICULT TO COMPARE PLANS WHEN PREMIUMS, COINSURANCE, DEDUCTIBLES, AND COVERAGE VARY WIDELY. LIKEWISE, ADVERSE SELECTION RESULTS IN HEALTH PLAN PREMIUMS THAT ARE ARTIFICALLY INFLATED DUE TO THE ADVERSE RISK OF THE ENROLLED GROUP. THESE FACTORS ARE VERY HARD TO JUDGE GIVEN THE INFORMATION PROVIDED BY OPM.

S. 1685 CREATES A SPECIAL INDEX FOR EACH PLAN OFFERED IN THE FEHBP. THE INDEX WOULD MEASURE THE TOTAL AMOUNT THAT AN ENROLLEE WOULD BE EXPECTED TO PAY OUT-OF-POCKET ON PREMIUMS, DEDUCTIBLES, CO-PAYMENTS, AND NON-COVERED SERVICES FOR THE MIX OF HEALTH CARE SERVICES AN AVERAGE INDIVIDUAL WOULD USE IN THE COURSE OF A YEAR. THE INDEX WOULD BE SIMILAR TO THAT USED BY CONSUMER CHECKBOOK IN ITS ANNUAL FEHBP GUIDE FOR FEDERAL EMPLOYEES. AND IT WOULD CONVEY THE SAME KIND OF INFORMATION PRESENTED BY MERCER IN THEIR EVALUATION OF FEHBP COVERAGE.

I'M HAPPY TO SEE, MR. CHAIRMAN, THAT THERE IS WIDESPREAD AGREEMENT THAT THE FEHBP NEEDS TO BE REFORMED TO ACCOMMODATE MEDICARE-ELIGIBLE FEDERAL EMPLOYEES. MY BILL PROVIDES MEDICARE-ELIGIBLE ANNUITANTS WITH A SPECIAL MEDICARE SUPPLEMENTAL PLAN. CURRENT HEALTH PLANS IN THE FEHBP ARE NOT DESIGNED AS MEDICARE SUPPLEMENTAL PLANS. YET MANY MEDICARE-ELIGIBLE ANNUITANTS ARE USING THEIR FEHBP COVERAGE AS A MEDICARE SUPPLEMENT--AT UNNECESSARILY HIGH COST TO THEM AND TO THE FEDERAL GOVERNMENT. IT IS IMPORTANT TO ASSURE THAT MEDICARE-ELIGIBLE ANNUITANTS HAVE THE KIND OF COVERAGE THAT BEST MEETS THEIR SPECIAL NEEDS.

EARLIER IN MY TESTIMONY I MENTIONED THE IMPORTANCE OF PREDICTABILITY IN THE FEHBP. OUR CURRENT SYSTEM FOR CALCULATING THE FEDERAL GOVERNMENT'S CONTRIBUTION IS UNWIELDY AND NEEDS REFORM. THE OFFICE OF PERSONNEL MANAGEMENT AND THE PARTICIPATING HEALTH PLANS SHOULD KNOW WELL IN ADVANCE OF EACH YEAR'S OPEN ENROLLMENT PERIOD WHAT THE GOVERNMENT CONTRIBUTION WILL BE. THE PRESENT ARRANGEMENT INVITES ARBITRARY, LAST-MINUTE ADJUSTMENTS THAT MAKE PRUDENT PLANNING IMPOSSIBLE. MY LEGISLATION INDEXES THE FEDERAL GOVERNMENT'S CONTRIBUTION TO THE ANNUAL PERCENTAGE INCREASE IN THE MEDICAL CARE COMPONENT OF THE CPI.

MR. CHAIRMAN, THE NEW PAYMENT SYSTEM WE HAVE ADOPTED FOR MEDICARE IS DESIGNED ONLY FOR THE MEDICARE POPULATION. MEDICARE IS AN INSURANCE PLAN, AND WE HAVE ADOPTED A PAYMENT SYSTEM THAT FITS THAT INSURANCE PLAN ONLY. THE DRG SYSTEM FOR HOSPITALS UNDER MEDICARE IS NOT DESIGNED FOR PRIVATE INSURANCE, AND WE SHOULD NOT BE TEMPTED TO BROADEN ITS USE. IN FACT, IT IS OUR DESIRE TO GET THE FEDERAL GOVERNMENT OUT OF THE INSURANCE BUSINESS ALTOGETHER, AND TO GET MEDICARE BENEFICIARIES ENROLLED IN PRIVATE HEALTH PLANS THROUGH THE VOLUNTARY VOUCHER. IN A SENSE, WE ARE STRUCTURING MEDICARE TO LOOK MORE LIKE THE FEHBP. WE SHOULD NOT TRY TO MAKE THE FEHBP LOOK LIKE MEDICARE.

FINALLY, MR. CHAIRMAN, LET ME REEMPHASIZE THE IMPORTANCE OF MULTIPLE CHOICE OF HEALTH PLAN AND EMPLOYEE COST-SHARING. THE FACT THAT EMPLOYEES HAVE A CHOICE OF HEALTH PLANS STIMULATES COMPETITION AND PRICE-SENSITIVITY IN THE PRIVATE SECTOR. THESE ARE FORCES WE HAVE NEVER BEEN ABLE TO STIMULATE THROUGH REGULATION. IT IS ONLY THROUGH THE WORKINGS OF A COMPETITIVE MARKETPLACE THAT PRICE-SENSITIVITY AND THE EFFICIENT DELIVERY OF SERVICES CAN BE ACHIEVED.

IF WE BELIEVE IN COMPETITION, IF WE BELIEVE IN THE FORCES OF THE PRIVATE SECTOR, IF WE BELIEVE IN INDIVIDUAL CHOICE, THEN WE MUST WORK TO STRENGTHEN THE BASIC DESIGN OF

THE FEHBP.

FEDERAL EMPLOYEES ARE NOT THE ONLY ONES WHO HAVE A STAKE IN A WELL-RUN FEHBP. MANY PRIVATE FIRMS AS WELL AS STATE AND LOCAL GOVERNMENTS MODEL THEIR PLANS AFTER THE FEHBP. IT IS IMPORTANT THAT WE MOVE AHEAD AGGRESSIVELY IN CORRECTING THE CURRENT PROBLEMS IN THE FEHBP, AND I LOOK FORWARD TO WORKING WITH YOU AND OTHER MEMBERS OF THIS COMMITTEE IN REACHING A CONSENSUS ON THE NECESSARY REFORMS.

STATEMENT OF
HONORABLE DONALD J. DEVINE
DIRECTOR, OFFICE OF PERSONNEL MANAGEMENT

before the

SUBCOMMITTEE ON CIVIL SERVICE, POST OFFICE, AND GENERAL SERVICES
COMMITTEE ON GOVERNMENTAL AFFAIRS
UNITED STATES SENATE

on

LEGISLATION RELATING TO THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

on

DECEMBER 1, 1983

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

I APPRECIATE THE OPPORTUNITY TO APPEAR TODAY TO DISCUSS VARIOUS PROPOSALS CONCERNING THE FEDERAL EMPLOYEES HEALTH BENEFITS (FEHB) PROGRAM. ACCOMPANYING ME THIS MORNING ARE JAMES W. MORRISON, JR., OPM'S ASSOCIATE DIRECTOR FOR COMPENSATION, AND JEAN M. BARBER, ASSISTANT DIRECTOR FOR FINANCIAL CONTROL AND MANAGEMENT IN THE COMPENSATION GROUP.

I WOULD LIKE TO BEGIN WITH S. 172, S. 178, S. 182, AND S. 198. THESE FOUR BILLS WOULD EACH REQUIRE FEHB PLANS, OTHER THAN COMPREHENSIVE PLANS, TO PROVIDE BENEFITS FOR COVERED SERVICES EVEN IF THOSE COVERED SERVICES ARE PROVIDED BY CERTAIN HEALTH PRACTITIONERS WITHOUT SUPERVISION OR REFERRAL BY A PHYSICIAN. THE BILLS WOULD APPLY TO SERVICES PROVIDED BY, RESPECTIVELY, NURSE PRACTITIONERS, NURSE-MIDWIVES, CERTAIN MENTAL HEALTH SPECIALISTS, AND COMMUNITY MENTAL HEALTH CENTERS. WE HAVE CONSISTENTLY OPPOSED STATUTORY BENEFIT REQUIREMENTS UNDER FEHB, SINCE SUCH STATUTORY REQUIREMENTS INHIBIT THE FLEXIBILITY NECESSARY IN THE COMPETITIVE, EVOLVING FEHB PROGRAM. WHILE WE THEREFORE OPPOSE THESE FOUR BILLS, THIS DOES NOT MEAN THAT WE ARE OPPOSED TO USE OF THESE INNOVATIVE APPROACHES

TO HEALTH CARE PROVISION. WE BELIEVE THAT USE OF NON-PHYSICIAN HEALTH PRACTITIONERS IN APPROPRIATE CIRCUMSTANCES HAS THE POTENTIAL FOR REAL COST SAVINGS, AS WELL AS FOR WIDENING THE CHOICES AVAILABLE TO ENROLLEES IN OBTAINING HEALTH CARE. WE INTEND TO PURSUE THIS ISSUE WITH THE CARRIERS AS WE NEGOTIATE PLANS.

S. 2027 AND S. 1685 ARE TWO MAJOR PROPOSALS THAT WOULD SUBSTANTIALLY CHANGE THE CURRENT FEHB PROGRAM. BRIEFLY, S. 2027 WOULD ADD PROVISIONS RELATING TO: MEDICARE SUPPLEMENTARY PLANS; MINIMUM BENEFITS COVERAGE; A REVISED GOVERNMENT CONTRIBUTION FORMULA, WHICH WOULD INCLUDE A HIGHER CONTRIBUTION RATE FOR MEDICARE-INELIGIBLE ANNUITANTS; CATASTROPHIC ILLNESS BENEFITS; AND COST CONTAINMENT. S. 1685 WOULD ENCOURAGE PROGRAM PARTICIPATION BY MORE PLANS, ADD ONE OR MORE MEDICARE SUPPLEMENTARY PLANS, AND PROVIDE A NEW GOVERNMENT CONTRIBUTION FORMULA.

WHILE WE HAVE GREAT SYMPATHY WITH THE OBJECTIVES OF BOTH OF THESE BILLS, WE BELIEVE THEY BOTH MOVE IN THE WRONG DIRECTION--NAMELY, GREATER GOVERNMENT INTRUSION INTO MATTERS THAT COULD BE BETTER HANDLED THROUGH RELIANCE ON COMPETITION BETWEEN HEALTH BENEFITS CARRIERS, AND FAR GREATER ADMINISTRATIVE COMPLEXITY IN A PROGRAM THAT IS ALREADY UNNECESSARILY BURDENSOME AND DIFFICULT TO ADMINISTER.

THIS DOES NOT MEAN THAT WE ARE SATISFIED WITH THE STATUS QUO. WE AGREE THAT THE FINANCING OF THE FEHB PROGRAM COULD BE REFORMED. THE CURRENT PROGRAM ALSO FAILS TO PROVIDE SOME ENROLLEES WITH THE TYPES OF COVERAGE THEY FEEL THEY NEED. OPM WANTS TO ENSURE THAT ALL FEHB ENROLLEES HAVE THE BROADEST POSSIBLE CHOICE OF HEALTH INSURANCE ALTERNATIVES, WHILE AT THE SAME TIME ENSURING THAT ANY PLAN OFFERED TO ENROLLEES IS FINANCIALLY SOUND. AND WE

ARE ACUTELY AWARE OF THE NEED TO ENSURE THAT THE PROGRAM WILL PROVIDE ADEQUATE AND AFFORDABLE PROTECTION FOR ANNUITANT ENROLLEES. WHILE S. 2027 AND S.1685 ADDRESS THESE AREAS IN VARIOUS WAYS, WE DO NOT SUPPORT THE OVERALL APPROACH TAKEN BY EITHER OF THESE BILLS, AND BELIEVE THAT THEY WOULD NOT BE IN THE BEST INTEREST OF ENROLLEES, AND WOULD RESULT IN UNACCEPTABLE INCREASES IN PROGRAM COSTS. THEREFORE, WE ARE ADVOCATING A DIFFERENT APPROACH TO REFORMING THE FEHB PROGRAM, AN APPROACH THAT WOULD EMPHASIZE THE TRADITIONALLY PRO-COMPETITIVE NATURE OF THE PROGRAM.

IT IS IMPORTANT TO RECOGNIZE THAT THIS ADMINISTRATION HAS ALREADY BEEN ABLE TO MAKE MAJOR PROGRAM IMPROVEMENTS WITHIN THE CONTEXT OF THE EXISTING FEDERAL EMPLOYEES HEALTH BENEFITS LAW. HERETOFORE, THE FEHB PROGRAM RECEIVED LITTLE TOP-MANAGEMENT ATTENTION. SUBSTANTIAL INCREASES IN HEALTH INSURANCE COSTS WERE ABSORBED WITHOUT SETTING RATES HIGH ENOUGH TO REFLECT THESE INCREASES. INSTEAD, WHILE PREMIUMS WERE HELD TO ARTIFICIALLY LOW LEVELS, RESERVE MARGINS WERE SHAVED IN RECENT YEARS AND NET INCOME TO THE FEHB TRUST FUND DROPPED FROM AN EXCESS OVER CLAIMS OF $232 MILLION IN FY 1978 TO A DEFICIT WITH RESPECT TO CLAIMS OF $442 MILLION IN FY 1981. SINCE NO ATTENTION HAD BEEN GIVEN TO UTILIZATION CONTROLS, UTILIZATION ROSE SHARPLY, INCREASING COSTS FOR AGENCIES, EMPLOYEES, RETIREES, AND TAXPAYERS. A LACK OF INTERNAL CONTROL SYSTEMS AT OPM LEFT TOP MANAGEMENT WITHOUT WARNING OF IMPENDING COST OVERRUNS.

MY ACTIONS TO DEAL WITH THESE CRITICAL PROBLEMS ARE WELL KNOWN. TO AVOID A $440 MILLION DOLLAR COST OVERRUN FOR THE GOVERNMENT, AND A SUBSTANTIAL INCREASE IN THE PREMIUMS PAID BY EMPLOYEES AND RETIREES, I ORDERED TWO ROUNDS OF BENEFIT REDUCTIONS DURING CONTRACT NEGOTIATIONS IN THE FALL OF

1981. THESE REDUCTIONS, WHICH WERE LATER UPHELD IN THEIR ENTIRETY BY THE U.S. COURT OF APPEALS, SAVED TAXPAYERS MORE THAN A QUARTER OF A BILLION DOLLARS AND CUT THE PREMIUM INCREASE EMPLOYEES AND RETIREES WOULD HAVE FACED IN HALF.

MOST OF THE REDUCTIONS WERE ACHIEVED, AT OPM'S INSISTENCE, BY INTRODUCING OR EXPANDING COST-SHARING FEATURES IN THE VARIOUS PLANS. IT IS A WELL-ACCEPTED PRINCIPLE OF INSURANCE PLANNING THAT COST SHARING LEADS TO DECREASED UTILIZATION LEVELS. YET, THE TREND UNTIL RECENTLY WAS AWAY FROM COST SHARING. AS A RESULT, THE AVERAGE HOSPITALIZATION STAY INCREASED FROM $22 PER DAY IN 1955 TO MORE THAN $100 PER DAY IN CONSTANT DOLLARS IN 1981 ($337 PER DAY IN CURRENT DOLLARS). MORE IMPORTANTLY, OUT-OF-POCKET EXPENSES BY PATIENTS THEMSELVES DECREASED FROM 30 PERCENT TO 11 PERCENT OF THE AVERAGE HOSPITAL BILL.

BY INTRODUCING OR EXPANDING DEDUCTIBLE AMOUNTS, CO-INSURANCE AND CO-PAYMENTS, WE REMEDIED A GLARING DEFICIENCY IN THE PROGRAM. UNTIL THIS POINT, SUCH FEATURES WERE EITHER CONSPICUOUSLY ABSENT OR TOO SMALL TO AFFECT UTILIZATION BEHAVIOR. THIS IS ESPECIALLY IMPORTANT IN THE AREA OF IN-HOSPITAL DEDUCTIBLES AND CO-INSURANCE, WHICH DID NOT EXIST IN THE PLANS WITH THE LARGEST ENROLLMENTS. BETWEEN 1970 AND 1979, PHYSICIAN EXPENSES INCREASED 8.8 PERCENT, BUT IN-HOSPITAL COSTS SHOT UP 14.8 PERCENT. CLEARLY, IF OVERALL COSTS WERE TO BE BROUGHT UNDER CONTROL, COST-SHARING HAD TO BE APPLIED TO IN-HOSPITAL COSTS AS WELL AS PHYSICIAN EXPENSES. INTERESTINGLY, JUST A FEW MONTHS AFTER THESE DECISIONS WERE MADE IN THE FEHB PROGRAM, A RAND STUDY WAS RELEASED WHICH DEMONSTRATED CLEARLY THAT THE USE OF DEDUCTIBLES AND CO-INSURANCE FEATURES WAS EFFECTIVE IN REDUCING UTILIZATION AND THE COST OF HEALTH CARE.

IT SHOULD NOT BE ASSUMED THAT COST AND UTILIZATION CONTROL FEATURES ARE UNPOPULAR WITH ENROLLEES IN THE FEHB PROGRAM. SUCH PRIVATE SECTOR FIRMS AS GENERAL MOTORS, CHRYSLER, FORD, U.S. STEEL, AND BETHLEHEM HAVE ADOPTED SUCH FEATURES. A NEW YORK TIMES POLL IN 1982 FOUND THAT ONLY 39 PERCENT OF THE PUBLIC DEMANDS FULL COVERAGE, WHILE A 54 PERCENT MAJORITY SAID THEY WOULD BE WILLING TO ACCEPT CHEAPER POLICIES WHICH DO NOT PROVIDE FULL COVERAGE. A LOUIS HARRIS SURVEY CONDUCTED IN AUGUST 1983 FOR THE EQUITABLE LIFE ASSURANCE SOCIETY REPORTED THAT 61 PERCENT OF THE PUBLIC FAVORS HEALTH PLAN TRADE-OFFS REQUIRING HIGHER DEDUCTIBLES AND INITIAL COST-SHARING IN RETURN FOR BETTER LONG-TERM BENEFITS. SIMILAR RESULTS WERE FOUND IN OUR OWN 1982 OPEN SEASONS, WHEN THOUSANDS OF ENROLLEES CHOSE TO SAVE MONEY BY MOVING INTO LOW OPTION PLANS, AND WILLINGLY TOOK ON A SHARE OF THE RISK OF INCURRING HEALTH COSTS IN RETURN.

DURING LAST FALL'S OPEN SEASON, FEDERAL EMPLOYEES AVOIDED A PROJECTED INCREASE IN THEIR INSURANCE COSTS OF 24 PERCENT. BY CHOOSING HEALTH CARE PLANS, WITH A VARIETY OF COST-SHARING FEATURES, THEY KEPT THE AVERAGE INCREASE IN THEIR PREMIUM COSTS TO ONLY 4 PERCENT. THIS INCREASE WAS WELL BELOW THE DOUBLE-DIGIT INCREASES IN MEDICAL COSTS GENERALLY. IN EFFECT, BY VIRTUE OF THE ADMINISTRATIVE REFORMS WE HAVE MADE IN THE FEHB PROGRAM, OPM HAS SAVED AMERICAN TAXPAYERS AND FEDERAL EMPLOYEES AT TOTAL OF $2 BILLION.

AS A RESULT OF ALL OF THESE ACTIONS TAKEN BY OPM, OUR LEGAL AUTHORITY HAS BEEN FIRMLY ESTABLISHED, WE ARE RECOVERING PREVIOUSLY SHAVED MARGINS, INTERNAL CONTROLS HAVE BEEN ESTABLISHED, EMPLOYEES HAVE BEEN ABLE TO AVOID INFLATED PREMIUM COSTS, AND THE PROGRAM HAS MOVED TOWARDS A SOUND FINANCIAL FOOTING.

MEANWHILE, THE ADMINISTRATION HAS BEEN PURSUING AN OVERALL CAMPAIGN AGAINST INFLATION IN HEALTH CARE COSTS, AS WITH INFLATION IN OTHER AREAS, BY RELYING ON MARKET-ORIENTED, PROCOMPETITION POLICIES THAT SEEK TO ENCOURAGE MORE COST-EFFICIENT METHODS OF DELIVERING SERVICES AND A GREATER AWARENESS OF THE COSTS OF BENEFITS AND SERVICES. IN KEEPING WITH THIS APPROACH, OPM HAS DEVELOPED A PROPOSAL FOR FEHB REFORM THAT HAS BEEN INTRODUCED IN THE HOUSE OF REPRESENTATIVES AS H.R. 3798. THIS PROPOSAL WOULD ENHANCE THE PROGRAM'S COMPETITIVE FEATURES AND IMPROVE INCENTIVES FOR INSURANCE CARRIERS, HEALTH CARE PROVIDERS, AND ENROLLEES TO CONTROL HEALTH CARE COSTS.

AS WE HAVE DISCUSSED BEFORE, OUR PROPOSAL WOULD UTILIZE WHAT IS POPULARLY KNOWN AS A "VOUCHER" SYSTEM. THE VOUCHER CONCEPT IS ONE THE ADMINISTRATION HAS PROPOSED PURSUING IN SEVERAL AREAS, INCLUDING MEDICARE, EDUCATION, HOUSING ASSISTANCE, AND UNEMPLOYMENT COMPENSATION, AND WE BELIEVE THIS APPROACH CAN MAKE A VALUABLE CONTRIBUTION TO THE FEHB PROGRAM TOO.

UNDER THIS SYSTEM, OPM WOULD NO LONGER NEGOTIATE DETAILED CONTRACTS WITH CARRIERS. INSTEAD, ANY CARRIER THAT IS PREPARED TO MEET CERTAIN REQUIREMENTS WOULD BE ADMITTED TO THE PROGRAM, AND WOULD BE FREE TO OFFER A VARIETY OF PLANS. ALL PLANS WOULD BE REQUIRED TO OFFER CASTROPHIC COVERAGE, CONSISTENT WITH STANDARD INSURANCE INDUSTRY PRACTICE, BUT WOULD BE ABLE TO DESIGN THEIR BENEFIT PACKAGES IN WAYS TO ADDRESS SPECIFIC NEEDS OF EMPLOYEE AND ANNUITANT GROUPS AND ATTRACT THE MOST ENROLLEES. ENROLLEES WOULD RECEIVE INFORMATION TO HELP THEM IN SELECTING THE PLAN BEST SUITED TO THEIR NEEDS.

THE GOVERNMENT CONTRIBUTION WOULD NO LONGER BE CAPPED AT THE CURRENT 75 PERCENT OF A PLAN'S PREMIUMS, SO ENROLLEES WOULD NO LONGER BE PENALIZED

FOR ENROLLING IN A LOW-COST PLAN. ENROLLEES WOULD EVEN BE ABLE TO RECEIVE REBATES IF THE PREMIUM FOR THE PLAN THEY CHOOSE IS LESS THAN THE AVAILABLE GOVERNMENT CONTRIBUTION. THE GOVERNMENT CONTRIBUTION WOULD NO LONGER BE DETERMINED BY THE COSTS OF PARTICULAR PLANS; THE LAW WOULD INSTEAD RELY ON A GENERAL PRICE INDEX TO ADJUST GOVERNMENT CONTRIBUTIONS.

FINALLY, OUR PROPOSAL WOULD REQUIRE THE U.S. POSTAL SERVICE AND THE DISTRICT OF COLUMBIA GOVERNMENT TO PAY THE GOVERNMENT CONTRIBUTION FOR THEIR ANNUITANTS, BECAUSE THE HIDDEN FEDERAL SUBSIDIES UNDER THE FEHB PROGRAM FOR THESE INDEPENDENT ENTITIES ARE NO LONGER APPROPRIATE.

WE BELIEVE THESE CHANGES COULD SUBSTANTIALLY IMPROVE THE FEHB PROGRAM. THEY WOULD OFFER EMPLOYEES A WIDER RANGE OF BENEFIT PACKAGES, AND THE CURRENT PENALTY FOR CHOOSING LOW-COST PLANS WOULD BE REMOVED. AT THE SAME TIME, ALL ENROLLEES WOULD BE PROTECTED AGAINST CATASTROPHIC MEDICAL EXPENSES. THERE WOULD BE STRONGER COMPETITION IN THE PROGRAM, AND ENHANCED INCENTIVES FOR CARRIERS TO CONTROL COSTS. THE USE OF AN INDEXED GOVERNMENT CONTRIBUTION WOULD CONTROL THE GOVERNMENT'S COSTS, THUS RESULTING IN SUBSTANTIAL SAVINGS IN GOVERNMENT OUTLAYS IN FUTURE YEARS, AND WOULD ACT TO RESTRAIN INCREASES IN HEALTH INSURANCE PREMIUMS, WHILE STILL ENSURING ADEQUATE HEALTH CARE FOR FEDERAL EMPLOYEES AND ANNUITANTS.

I WOULD BE HAPPY TO ANSWER ANY QUESTIONS THE SUBCOMMITTEE MAY HAVE NOW.

UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

FOR RELEASE ON DELIVERY
Expected at 10:00 A.M.
Thursday, December 1, 1983

STATEMENT OF

MICHAEL ZIMMERMAN
ASSOCIATE DIRECTOR, HUMAN RESOURCES DIVISION

BEFORE THE

SUBCOMMITTEE ON CIVIL SERVICE, POST OFFICE
AND GENERAL SERVICES
OF THE
SENATE COMMITTEE ON GOVERNMENTAL AFFAIRS

ON

LEGISLATION TO AMEND THE FEDERAL EMPLOYEES HEALTH BENEFITS ACT

Mr. Chairman and Members of the Committee:

I appreciate this opportunity to comment on the legislation being considered by the Committee to amend the Federal Employees Health Benefits Act. My statement will highlight our views on the major features of the three bills[1] before the Committee. We will be glad to submit more detailed comments later.

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[1]S. 2027, "Federal Employees' Health Insurance Amendments of 1983";

S. 1685, "Federal Employees Health Plan Improvement Act of 1983"; and

H.R. 3798, "Federal Employees Health Benefits Reform Act of 1983."

Before discussing these bills, however, I would like to mention our February 1983[2] report to you, which described issues that persons familiar with FEHBP perceived as needing to be addressed to better assure the program's stability. We reported on four major issues:

1. Greater health care cost containment efforts are needed. This is evidenced by the chart attached to my statement which shows the program's cost growth in the last decade in relation to total national health care expenditures. In many ways FEHBP's cost problems are a microcosm of the health care cost issues facing our society and until ways are found to control the general escalation of health care costs, FEHBP's cost will continue to rise and remain a serious problem.

2. The lack of predictability over budgeting for the government's contribution toward health plan premiums was a major reason why the program encountered severe budgetary shortfalls, which led to Office of Personnel Management administrative actions in 1981 and 1982 to reduce benefits. When the annual budget estimates are prepared, there is little way to accurately predict future plan premiums. Further, anticipated enrollment levels for the individual plans are not known at that

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[2] "Financial and Other Problems Facing the Federal Employees Health Insurance Program," GAO/HRD-83-21, February 28, 1983.

time and thus are not factored into the budget estimates. Both premiums and enrollment levels ultimately determine the government's cost. This uncertainty about enrollment levels was illustrated during the past two open seasons (May 1982 and November 1982), when about 20 percent of FEHBP enrollees switched plans.

3. Contrary to congressional intent, FEHBP is not comparable to health programs of large private sector employers in terms of either the level of benefits offered or the employer's contribution--the government's benefits and contributions are lower.

4. Selective enrollment, resulting from consumer choice, is perceived by some participating plans to be a problem. Over time, low and high utilizers of health care are segregated into different plans, causing some plans' enrollment to consist of a disproportionate number of higher than average utilizers. Premiums for such a plan must reflect the cost of insuring these people, which in turn makes the plan's premiums unattractive to low utilizers and causes them to move to less expensive plans, leaving the plan with an even more expensive group of enrollees. This problem may ultimately make comprehensive coverage either unaffordable or unavailable to those who need it most, such as the chronically ill and those in need of a specific benefit, such as treatment for mental disorders.

Our comments on each of the bills as they relate to these issues follow.

Cost Containment

S. 2027 establishes a cost containment program which emphasizes (1) peer review of the utilization and quality of health care delivered, (2) the use of deductibles and copayments, (3) the design and offering of alternative, more cost effective types of medical care, and (4) the adoption of Medicare reimbursement rules. We believe these actions are needed and can contribute to containing health care costs in FEHBP. In particular, we believe that the government should begin to adopt a more uniform approach for reimbursing health care providers that participate in government-financed health programs.

Specifically, as part of the Social Security Amendments of 1983, the Congress adopted a major reimbursement reform which features a prospective payment method for inpatient hospital care under Medicare. This method, which will be phased in over 3 years beginning in October 1983, discarded Medicare's traditional cost-plus reimbursement methodology and replaced it with a system designed to pay all hospitals relatively fixed amounts per admission based on a patient's diagnosis. If a hospital's costs per admission and diagnosis are less than the prescribed payment rate, it can keep the difference; however, if the costs are more, it will have to either absorb the losses or, more likely, pass them along to other payors such as FEHBP. Therefore, we believe that the provisions of S. 2027 which are intended to conform FEHBP's reimbursement rules to Medicare with respect to inpatient hospital services represent desirable reforms. However, Medicare has not developed a corresponding prospective payment system for other services and other providers such as physicians. Although there are differences in the mechanics and the resulting amounts allowed, FEHBP uses essentially the same reimbursement approach as Medicare for these providers. Therefore, considering the administrative complexities involved in conforming to Medicare's allowances, we see no reason at this time to extend Medicare's methods to FEHBP for other than inpatient hospital services. At such time as Medicare develops alternative methods, we believe it would then be appropriate to look at these alternatives for possible application to FEHBP.

It should be recognized that such an approach for inpatient hospital services will take several years to implement and should be closely coordinated with the health care industry as well as the Department of Health and Human Services, which is developing the system for Medicare and can provide valuable assistance to FEHBP. In addition and perhaps most importantly, FEHBP should assure that beneficiaries are protected from the cost of hospital services in excess of the allowable amount or identified as unnecessary through the proposed peer review program.

S. 1685 and H.R. 3798, as we interpret them, rely greatly on increased competition among health plans as a means for containing costs. Such health care competition models offer the potential for restraining the growth in health care costs but are virtually untested; therefore, little is known about whether they will succeed in substantially moderating health care cost increases.

Budgeting for Program Costs

S. 2027 provides that the government's contribution toward health plans be based on a weighted average of the premiums charged by all participating plans. In other words, the enrollment level of each plan would be used to determine the government's contribution. If the expected enrollment level of the individual plans can be factored into the budget estimates this should improve their predictability. However, the same difficulties and uncertainties would remain in estimating how much each plan's premiums will change from year to year.

S. 1685 generally would provide that the government's contribution be adjusted annually by the percentage increase or decrease in the medical care expenditure category of the Consumer Price Index for All Urban Consumers. This process would improve the predictability of the government's contribution amount because of its independence from plans' premium rates.

H.R. 3798 proposes annual adjustments to the government's contribution in an amount equal to the percentage change in the implicit price deflator of the Gross National Product. This too would make budget estimates more accurate and predictable than they are now.

Comparability to Private Industry

S. 2027 would increase the government's share of premium payments from 60 to 70 percent for active employees and Medicare-eligible annuitants and to 84 percent for annuitants not eligible for Medicare hospital benefits. Such a change would lessen the disparity between what large private sector employers contribute to health plans and what the government contributes. On the other hand, this provision would add to the government's cost.

Neither S. 1685 nor H.R. 3798 specifically provides for adjustments to narrow the gap between employer contributions for private and federal employee health insurance.

Selective Enrollment

None of the bills would eliminate selective enrollment because consumer choice would remain in the program. S. 1685, however, would mitigate the adverse effects this phenomenon has on plans by adjusting the government payment to plans based on the utilization, age, sex, and geographic location of their enrollees. In other words, the government would provide additional compensation to plans that enroll the sicker and/or more costly beneficiaries. We have concerns, however, regarding the complexity of administering such a system because of the large data collection and analysis efforts that would be required by OPM.

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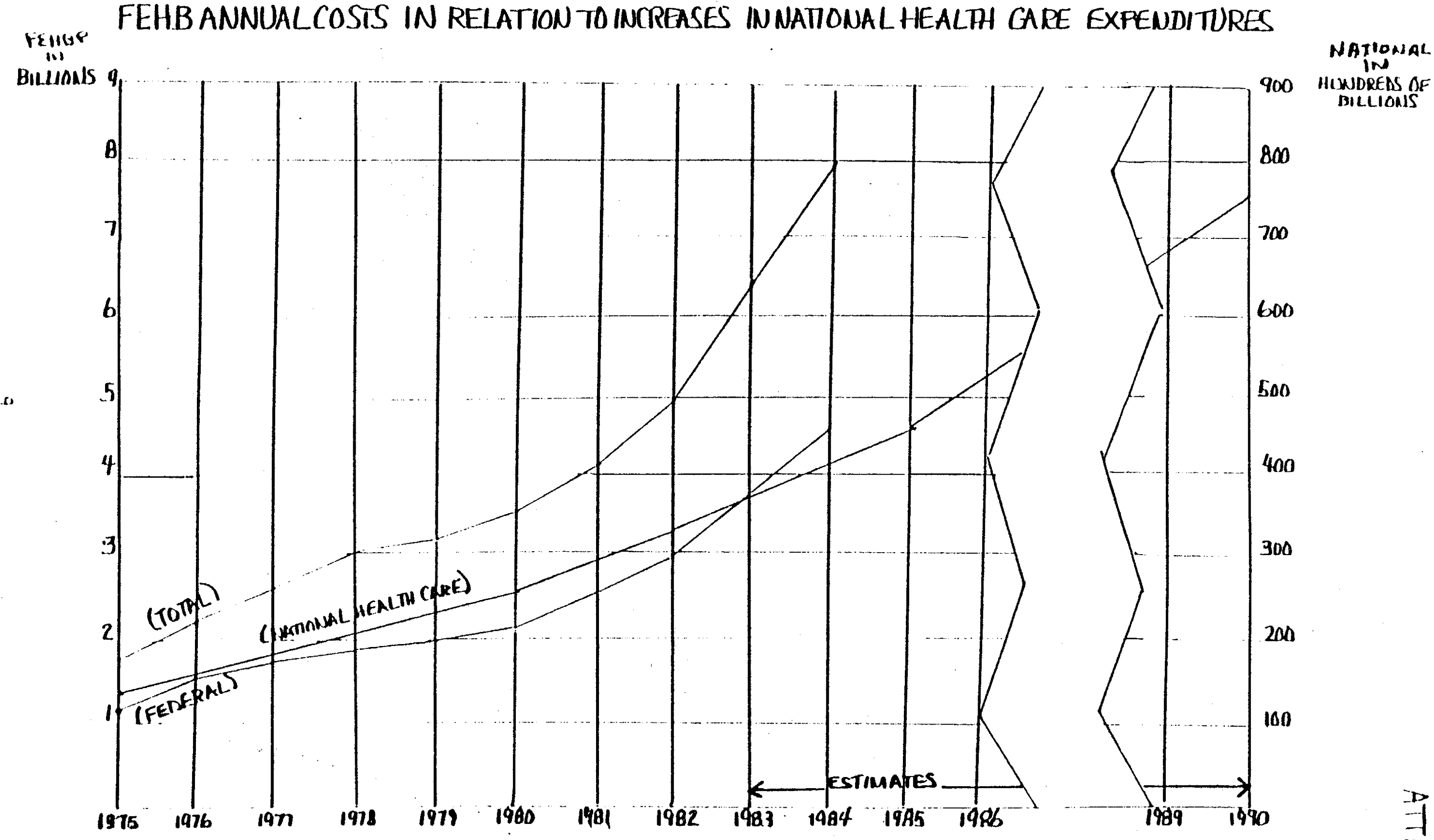
I would like to address one additional matter. S.2027 requires that every 2 years the Comptroller General review and report to the Congress on the activities carried out by utilization and peer review organizations created by the amendments. Under section 204 of the Legislative Reorganization Act of 1970, as amended, our Office is required to perform any reviews requested by committees of jurisdiction. We believe such an arrangement would be more mutually advantageous than a specific legislative requirement because it would allow us, through discussions with the committee, to focus our audit efforts on the matters of greatest concern to the committee. Accordingly, we recommend that the requirement for periodic Comptroller General reviews and reports on the activities of the utilization and peer review organizations be deleted from the bill.

That concludes my prepared statement Mr. Chairman. We would be glad to answer any questions you may have.

FEHB ANNUAL COSTS IN RELATION TO INCREASES IN NATIONAL HEALTH CARE EXPENDITURES



SOURCES: FEHB COSTS OBTAINED FROM U.S. GOVERNMENT ANNUAL BUDGET, FY 1977-1984
NATIONAL HEALTH CARE EXPENDITURES OBTAINED FROM HEALTH CARE FINANCING ADMINISTRATION

ATTACHMENT

Statement of Maurice J. Twomey
Chairman
Employee Organization Federal Employees
Health Benefits Program Association (EOFEHBPA)

on pending

Federal Employees Health Benefits Legislation

Before the

Subcommittee on Civil Service, Post Office,
and General Services

United States Senate

December 1, 1983

Federal Employees Health Benefits Legislation

Mr. Chairman, Members of the Subcommittee, I am Maurice J. "Mo" Twomey, Vice President of the National Association of Postal Supervisors and Chairman of the Employee Organization Federal Employees Health Benefits Program Association (EOFEHBPA). Our Association appreciates this opportunity to appear before the subcommittee as it considers pending bills to amend the Federal Employees Health Benefits Act (FEHBA).

Ours is a voluntary Association of Employee-Organization sponsored health benefits plans under the Federal Employees Health Benefits Program (FEHBP). Our membership includes nine plans:

--the National Rural Letter Carriers Plan;
--the Special Agents Mutual Benefit Association Plan;
--the Mail Handlers Plan;
--the National Association of Government Employees Plan;
--the National Association of Postmasters of the United States Plan;
--the National Federation of Federal Employees Plan;
--the Government Employees Benefit Association Plan;
--the National Association of Postal Supervisors Plan; and
--the National League of Postmasters Benefit Plan.

Our testimony today reflects the consensus view of our Association membership, as developed over many months of consultation and analysis.

Mr. Chairman, the Association is fully aware of the diligent effort that you and your subcommittee staff have made to develop legislation that is responsive to the needs of Federal Employees for effective health benefits as part of their employment benefits. We have appreciated the requests of your staff for our comments on each successive draft bill. Over the past year we believe these consultations have been productive in a number of significant areas. We will value the continuing opportunity to work with you as the process continues in the next Session of the Congress.

The Association's Basic Position

Mr. Chairman, the Association, as you know, has maintained consistently that the FEHBP is fundamentally sound. We have contended that the Program needs reform in only three respects. First, the Government Contribution should be increased to reflect more nearly the current practices among large private employers and large non-Federal public employers. The FEHBP requires Federal and postal employees and annuitants to pay, on the average, too large a part of their health insurance costs. Second, the Program suffers from a serious annuitant underfunding problem. The claims costs of annuitants are so high that active employees are required to cross-subsidize the coverage extended to the retired population within the Program. Third, there are a number of management problems within the Office of Personnel Management (OPM) which apparently require direct Congressional action to resolve.

As it has evolved over the years, the FEHBP has come to rest upon two basic principles for its strength and for its acceptance by employees: freedom-of-choice during open enrollment periods, and intense competition among participating plans. While all benefits packages and premium rates are approved under OPM contract with individual plans, there is sufficient diversity among plans to ensure vigorous competition. All Federal and postal employees and annuitants have the freedom to choose a plan best suited to their respective individual needs. That freedom must be maintained.

Nevertheless, Mr. Chairman, as all responsible studies have demonstrated, the Government contribution is too low compared to major private-sector and non-Federal public sector plans now in effect.

The Association has strongly recommended an increase to 75 percent of the so-called "Big Six" average subscription charge. As introduced, S. 2027 would increase the Government Contribution, but the increase would be limited to 70 percent of the weighted average subscription charge. There is a continuing need to maintain comparability with major private-sector employers in providing health and other fringe benefits. Our proposal on this issue deserves strong bi-partisan support within the Congress.

Mr. Chairman, all major bills before Congress to amend the FEHBA recognize the difficult problem of annuitant underfunding. For reasons which are apparent, the elderly are the highest utilizers of health care. Of the $168 billion spent on personal health care in 1978, about 29 percent was spent on persons aged 65 and over -- only 11 percent of the population. The average medical care bill in that year for the 65-and-over age group was $2,026, compared with $762 for the 19-64 age group and $286 for the under-19 age group. Without a substantial Supplemental Government Contribution to help cover the cost of annuitant coverage, active employees will continue to bear--through cross-subsidy--a large portion of annuitant costs.

S. 2027 is intended to provide a Supplemental Government Contribution equal to 20 percent of the average subscription charge for each enrolled annuitant who is not Medicare-eligible. The principal bill before the House would provide a 5 percent differential payment for employees and annuitants who are 65 and older, and who are not Medicare-eligible. Senator Durenberger's bill would provide a higher annuitants' Government Contribution through a formula to be devised by OPM.

The difficulty, Mr. Chairman, is that none of these proposals will eliminate the cross-subdsidy now burdening the active employees. Our specialists have determined that the average non-Medicare eligible annuitant over 65 has claims costs that are 250 percent of those of the average active employee. The average Medicare-eligible annuitant over 65 still has claims costs equal to those of active employees in the 30-39 year age group. Thus, if cross-subsidy is to be eliminated and the annuitant underfunding problem is to be completely resolved, the required Supplemental Government

Contribution will amount to about 20 percent of the average subscription charge for all annuitants, regardless of Medicare-eligibility. Of course this supplemental payment could be structured to decline over time, as more and more annuitants over the age of 65 become Medicare-eligible. In materials provided separately to your subcommittee staff, the Association has provided a formula for declining Supplemental Government Contribution to reflect the decline over time in the proportion of annuitants who are not Medicare eligible.

Mr. Chairman, the Association believes that both Congress and the Administration should support a transitional provision which eliminates the transitory problem of annuitant underfunding within the Program. We will be pleased to continue to work with your staff toward that end.

The Association has argued that no participating plan should be permitted to exclude annuitants from its rolls; that all Employee Organization plans should be required to demonstrate financial responsibility; that an Open Season should be held before premium rates or benefits are changed; that the audits performed by OPM should concentrate on claims-payment experience and performance; that OPM should be required to reconcile enrollment and premium information; and that program administration by OPM, generally, should be strengthened. Mr. Chairman, we are pleased to note that your bill, S. 2027, addresses in various ways each of these problem areas.

Cost Containment

Mr. Chairman, S. 2027 contains comprehensive cost containment features which -- because of their complexity -- require the most thoughtful and careful analysis. As a general proposition, all plans within the Association depend upon cost containment for survival and competitive parity. It is not in the interests of the Program for all plans to have the same cost containment features. For example, some of our plans have found that peer review has been successsful in controlling costs in selected areas where enrollment-concentration justifies such an approach. Preferred provider agreements may be important intitiatives for some plans in selected areas of the country. Coordination of benefits is an accomplished fact -- but subrogation against third parties, in all cases, would be an administrative nightmare, cost-ineffective, and counter-productive when minor claims are at issue.

Mr. Chairman, it should be noted that OPM requires an annual submission where each plan must review their cost containment initiatives for the Agency. Moreover, in all benefit submissions for at least the past two years, OPM has considered only those benefit revisions that "enhance" the cost containment features of the Plan.

OPM has the responsibility, in the final analysis, to ensure that cost containment programs administered by the respective plans are effective. Under the terms of S. 2027, the "independent audits" of the plans would be conducted by various and sundry auditors, selected by the individual plans, operating under contract approved by OPM. Mr. Chairman, we have two concerns. First, the audits would essentially be standardless, and OPM would have nothing but "apples and oranges" to compare from the results of the program. Second, the proposal permits OPM to abdicate its fundamental responsibilities of administration and program management. The audits will cost real dollars -- premium dollars -- whether conducted by OPM or "independent auditors." The better idea, in our view, would be for OPM to perform the assigned responsibilities, under criteria developed by OPM, as the Agency is now supposed to do.

Mr. Chairman, the centerpiece of cost containment in S. 2027 is the requirement that OPM, jointly with HHS, should promulgate regulations establishing maximum charges payable under FEHBP for various types of health care. These maximum charges would be set "to the extent practicable" in accordance with Medicare reimbursement rules, and would place a ceiling on the amounts that a provider could receive in reimbursement from any party, including the enrollee.

There are a number of questions which arise from this proposal. How will health care providers respond in Washington, D.C., where the predominant employer is the Federal government? How will they respond in Anchorage, or Santa Fe, or Baltimore, where the Federal government commands a relatively smaller share of the employment market? Will Federal and postal employees in outlying regions suffer discrimination in receiving health care? Will the potential for cost-shifting to the non-Federal sector alienate Federal and postal employees from their neighbors, who apparently will be required to carry a heavier load?

Our Association recognizes that this proposal, as part of S. 2027, is a most complex and serious one. We believe that our response must be fully thought out -- and that will require more time and analysis.

Medicare Supplemental Plans

Mr. Chairman, S. 2027 provides that each plan may offer a Medicare Supplemental Plan in addition to its regular plan or plans. Our Association does not favor this provision of the bill.

Those annuitants who are over 65 years of age and who are Medicare-eligible are advised by their various association representatives to purchase Part B when they are eligible for the most favorable rates, and to enroll in a low-cost FEHBP plan which provides coverage equivalent to the best so-called "Medicare Supplemental Plans" now on the private market. About 70 percent of all FEHBP annuitants over the age of 65 are Medicare-eligible at this time. They are an essential cohort within the FEHBP population. The principles of group insurance demand that they remain within that basic population. If they are encouraged to select plans for which they alone are eligible, the burdens of funding the health care costs of non-Medicare eligible annuitants will fall -- even more heavily than today -- upon the active-employee cohort. Thus, almost everyone within the program will be a loser: the active employees; the non-Medicare-eligible annuitants over the age of 65, all annuitants under the age of 65; and, possibly, those for whom the special plans are designed. There has been no showing that the Medicare Supplemental Plans, after a year or two of experience rating, will be more cost-effective than the combination of Part B and one of the various low-cost options now available to all employees and annuitants without discrimination within the Program.

There are a number of provisions of your bill, Mr. Chairman, which benefit everyone: the increase in Government Contribution, the Supplemental Governmental Contribution for annuitants (though inadequate to solve the total problem); and other nondiscriminatory features we have discussed. There is no reason for this legislation to extend improved benefits with one hand, then take away certain benefits now enjoyed by the majority of enrollees with the other.

Conclusion

Mr. Chairman, the Association strongly opposes the Administration's so-called "voucher system." And the Association does not favor enactment of Senator Durenberger's bill. Because of the constraints of time, we will -- with your permission -- submit for the hearing record detailed written comments on those two measures.

Over the past year, we have especially appreciated the opportunity to work with you and with your staff on this legislation of the highest importance to our Employee Organizations, and to all Federal and postal employees and annuitants. We anticipate that this excellent working relationship will continue. On behalf of all our members, we thank you for this opportunity to testify, and we will attempt to answer any questions you might have at this time.

Thank you, Mr. Chairman.

National Council on Alcoholism inc. Public Policy Office
1100 17th STREET, N.W. • SUITE 710 • WASHINGTON, D.C. 20036 • (202) 223-1998

STATEMENT OF

THE NATIONAL COUNCIL ON ALCOHOLISM

Submitted To

THE CIVIL SERVICE, POST OFFICE & GENERAL SERVICES SUBCOMMITTEE
GOVERNMENTAL AFFAIRS COMMITTEE
U.S. SENATE

On Provision of Alcoholism Treatment Benefits Under Health Plans for Federal Employees

At a Hearing on S. 2027, Federal Employee Health Benefits Program

December 1, 1983

The National Council on Alcoholism, the nation's largest and oldest voluntary organization in the field of alcoholism, wishes to extend special thanks to the Chair and members of this Subcommittee for the opportunity to testify today on S. 2027 and the issue of coverage for alcoholism treatment and rehabilitation under the health plans for federal employees.

The lack of adequate and appropriate coverage of alcoholism treatment for federal workers has been a source of keen concern since passage of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (the Hughes Act) and inauguration of the federal alcoholism effort. This law (Public Law 91-616) made the Office of Personnel Management (OPM), then the Civil Service Commission, "responsible for developing and maintaining in cooperation with the Secretary (of Health and Human Services) and with other federal agencies and departments ... appropriate prevention, treatment and rehabilitation programs and services." The Hughes Act was followed by Public Law 92-255, the Drug Abuse Office and Treatment Act of 1972, which requires federal agencies to establish and maintain drug abuse programs. Although there have been extensive overhauls and recodifications of both the Hughes Act and the Drug Abuse Office and Treatment Act during the past decade, these mandates have survived and remain on the statute books.

It should be noted that the range of services now being provided for mental and emotional problems among federal employees came about largely as a result of the initial alcoholism programs, and, according to the General Accounting Office in a 1980 report, the mental health programs are generally considered by-products of the earlier efforts to carry out the Hughes Act mandate.

These programs -- called occupational alcoholism programs, employee assistance programs, or employee counseling services -- generally are directed at identifying alcohol and drug problems, referring employees to community resources for treatment, and following up on workers in treatment and in readjusting to jobs following treatment. From the beginning of the effort to provide these services, it was recognized that a major impediment to the institution of effective employee assistance programs was the paucity of coverage for alcoholism treatment under the federal plans, most notably the Blue Cross/Blue Shield Service Benefit Plan. It is axiomatic in the employee assistance field, which has experienced great growth in the private sector during the past decade, that identification and referral of workers with alcohol problems is a futile exercise when third-party mechanisms are inadequate to support their treatment and rehabilitation.

The National Institute on Alcohol Abuse and Alcoholism (NIAAA), created by the Hughes Act, launched initiatives shortly after its inception designed to facilitate health insurance coverage for citizens afflicted with alcoholism. The first decade of the Hughes Act focused on federal funding of demonstration treatment programs, but always with the idea that the federal government could not bear the burden of providing such treatment on an ongoing basis. The effort was to incorporate treatment of alcoholism into the mainstream of the nation's health care system through appropriate public and private third party coverage. There were a number of components to the third party initiative by NIAAA, including a contract with the Joint Commission on Accreditation of Hospitals to develop standards for alcoholism programs, projects with Blue Cross/Blue Shield and the Group Health Association of America, and a program to develop credentialing standards and procedures for alcoholism counselors, to cite a few. These projects had the dual objectives of assuring that quality services would be available for alcoholism treatment in terms of both programs and personnel and demonstrating that treatment of alcoholism could be covered by health insurance plans on a basis that was not only cost effective but actually cost beneficial.

Although NIAAA is still significantly engaged in this effort, we believe that the original objectives have been substantially achieved insofar as making the case that alcoholism coverage under third-party systems is both feasible and desirable in economic as well as humane terms.

In 1979, the National Advisory Council on Alcohol Abuse and Alcoholism, an adjunct to NIAAA, formed a four-member subcommittee to look into what amounted to a large hole in the third-party fabric for alcoholism coverage ... lack of adequate benefits for federal workers under the Blue Cross/Blue Shield plan. In a report to a meeting of the Advisory Council in May, 1980, the subcommittee chairman, Riley Regan, Director of the New Jersey Division of Alcoholism declared that the federal government was "losing millions of dollars through inappropriate and inefficient treatment of employees with alcoholism."

"We are now thoroughly convinced that the federal government is acting irresponsibly," Regan said. At the time, the Blue Cross/Blue Shield Service Benefit Plan, which covers about half of the estimated 10 million federal workers, dependents and annuitants, limited benefits to hospital-based detoxification of from five to seven days. The Advisory Council Subcommittee recommended extension of benefits to cover rehabilitation, including stays in less costly free-standing residential alcoholism programs. It is noteworthy that considerable Congressional support was evinced at that time for such an extension of benefits. Sen. Orrin Hatch, now Chairman of the Senate Labor and Human Resources Committee and then ranking Republican on the Alcoholism and Drug Abuse Subcommittee, wrote a letter to the Office of Personnel Management, urging expanded health insurance coverage for federal employees under Blue Cross to include "reimbursement to cost-effective free-standing non-hospital providers." He said in a June 30, 1980 letter to Kenneth Lease, then Chief of OPM's Government-wide Plans Division:

"I feel strongly that utilization would justify the expanded coverage and the corresponding reduction of inpatient costs of high-cost medical facilities would more than offset the costs for providing greater coverage."

The expanded coverage, Hatch concluded, "makes sense from both a better management viewpoint as well as an employee point of view in assuring a healthy and productive work force."

On Sept. 23, 1980, the Office of Personnel Mangement announced that the Blue Cross/Blue Shield Service Benefit Plan would add inpatient alcoholism treatment benefits for federal workers beginning in 1981. The new coverage consisted of up to 28 days of inpatient care per session with a life-time limit of two sessions. Moreover, coverage was extended to approved free-standing facilities as well as hospital-based programs -- a move favored by major segments of the field concerned about rising costs of hospital care. The additional benefits were perceived as a major breakthrough on the third-party front for the alcoholism treatment field -- not only because of the millions of federal workers, dependents and annuitants now offered alcoholism benefits for the first time, but because the size and visibility of the federal BC/BS plan place it in the role of a trend-setter for the health insurance industry at large. And perhaps even more important was the elimination of the negative signal imparted by the fact that the federal government's flagship health insurance program failed to provide appropriate coverage for alcoholism.

We furnish this background in the hopes that this Subcommittee will appreciate that the total wipe-out of the alcoholism inpatient benefit only one year after its achievement had a significance transcending the bald fact of its demise. It represented, at a time when the first budgetary cutbacks were being imposed on the federally funded treatment programs, the first major setback in a decade of steady advances in third-party coverage for alcoholism treatment, and was seen as a possible harbinger of slippage across the whole front of health insurance benefits for alcoholism.

It should be noted also that outpatient benefits for alcoholism treatment under the federal Blue Cross/Blue Shield have always been available under the psychiatric coverage. Thus the cutbacks in mental health outpatient coverage sharply reduced the availability of outpatient services for alcoholism as rendered in psychiatric settings.

That the alcoholism inpatient benefit was dropped in an almost mindless fashion became apparent when the field attempted to get an explanation for the action. A Blue Cross/Blue Shield vice president said at a public meeting of the Interagency Committee on Federal Activities for Alcohol Abuse and Alcoholism on May 3, 1982, that this organization was responsible for the actual decision to drop the benefit. He said the action was in response to the directive by OPM to reduce benefits by about $150 million as the Blue Cross/Blue Shield share of the overall reductions. The alcoholism benefit cost an estimated $7 million for the brief time it was in effect, and was dropped, according to the BC/BS official, because its loss would not affect many people. Yet, he said the benefit experienced a dramatic rise in utilization in the third quarter of 1981 as providers geared up for it. The official, William Gillman, estimated that BC/BS paid for about 3,250 cases under the rehabilitation benefit during 1981, but conceded that this estimate was derived from raw data that did not separate detoxification from rehabilitation.

The field was confronted with a bewildering hydra-headed rationale -- that the benefit was dropped as an economy measure because of its costs and at the same time, its utilization was low and its elimination would not affect many people. One fact was clear, however. Blue Cross/Blue Shield made the decision to drop the alcoholism inpatient benefit without any serious scrutiny of its brief experience with the benefit. Four months after the benefit was eliminated, the senior official in charge of the federal plan conceded that the data on actual utilization of the new benefit were not available. Moreover, although there had been close collaboration between Blue Cross/Blue Shield and HHS officials and field groups in the inauguration of the benefit, the coverage was dropped by Blue Cross/Blue Shield unilaterally without even touching bases with those representing the interests of the alcoholic.

As much as we deplore the benighted policies of the Office of Personnel Management which imposed the false economies on the carriers, we believe that Blue Cross/Blue Shield should also be held accountable for the elimination of the alcoholism benefit -- an action whose repercussions have been extensive and deleterious not only for federal workers and their families affected by alcoholism but, by its negative example, to the millions of alcoholics outside the federal establishment who today do not have adequate health insurance coverage for their disease.

It should be noted that the national Blue Cross and Blue Shield Association, headquartered in Chicago, has joined with the Alcohol, Drug Abuse and Mental Health Administration in an announcement that beginning next summer, a generous alcoholism and drug abuse benefit will be a required component of health plans offered to national accounts. Each BC/BS plan is being directed to include the recommended Substance Abuse Rehabilitation Benefit as part of the standard package of the so-called Matrix Contract to national accounts. Moreover, tha national Blue Cross/Blue Shield organization is actively encouraging its member plans to use the recommended benefit for existing national accounts. We would hope that this benefit, endorsed by an agency of the Public Health Service under the current Administration as well as the national Blue Cross/Blue Shield organization would be heeded by the federal Blue Cross/Blue Shield program, the Office of Personnel Management as well as federal legislators interested in making important revisions in the federal health insurance program. Much has been made of the need for the federal sector to be competitive with the private sector in terms of salaries and benefits if top notch workers are to continue to be attracted to public service. This recent announcement by national Blue Cross and Blue Shield indicates that other national employers are about to take great leaps forward in the provision of comprehensive alcoholism and drug abuse services as a covered benefit. Do our federal employees deserve any less and can the federal government continue to afford to offer less? NCA thinks not.

The National Council on Alcoholism, by action of its Board of Directors in February, adopted a resolution stating our strong support for legislation mandating alcoholism treatment benefits in all health plans offered federal workers. A copy of the resolution is attached.

The reasons for our position on alcoholism coverage for federal workers are basically those behind our support for adequate and appropriate coverage for alcoholism for the population at large and have led us to the position that such coverage be mandated. Our position arises from our belief that:

-- Alcoholism is a separate disease entity of primary diagnosis as defined by NCA in 1972. ("Alcoholism is a chronic, progressive and potentially fatal disease. It is characterized by tolerance and physical dependency or pathologic organ changes, or both -- all the direct or indirect consequences of alcohol ingested.") Continuing research and clinical advances are furnishing overwhelming documentation and scientific validation of physiological and biochemical factors in the etiology of alcoholism.

-- Alcoholism is a treatable disease, and treatment is effective. Clinical outcome studies indicate an average improvement rate of about two-thirds for treated alcoholics, according to the Congressional Office of Technology Assessment in a March, 1983 report on the Effectiveness and Costs of Alcoholism Treatment.

-- Treatment of alcoholism is cost beneficial. Cost benefit analyses show significant reductions in medical care utilization and time lost to illness, not only among alcoholics themselves but among their families.

-- Failure to provide third-part reimbursement for alcoholism treatment is far more costly than benefits for alcoholism treatment. This fact has been increasingly recognized in the private sector by both employers and insurance carriers. Medical and emotional problems of alcoholics and their families show up in a range of other health services. Moreover, alcoholism and its consequences are being treated under surrogate diagnoses in expensive and inappropriate settings, particularly in populations where specific comprehensive coverage for alcoholism is not mandated. Heavy alcohol consumption has a pervasive negative impact on the body including the gastrointestinal tract, the liver, brain and nervous system, heart, muscle and endocrine system, according to the National Institute on Alcohol Abuse and Alcoholism. A Blue Cross/Blue Shield study of more than 300,000 workers in three states showed that alcoholics and drug abusers used eight times more hospital days than other insured employees for conditions other than alcoholism or drug abuse. A recent policy statement of the American Hospital Association indicated that alcoholism and drug abuse problems are seen in as many as 50 percent of the patients admitted to hospitals with other diagnoses. AHA goes on to argue that "recognition of alcoholism and other chemical dependence can result in earlier diagnoses of ... al hospital admissions " and affirms that "discriminatory clauses that exclude coverage for alcoholism and drug addictions must be eliminated from national and local insurance contracts." We are now operating in a day of virtual consensus in the health care field that early and appropriate treatment for alcoholism can stem the development of a variety of alcohol-related conditions and reduce the need for high-cost hospital stays for their treatment.

-- Alcoholism benefits are not costly. An analysis of data collected by Aetna on utilization and charges experienced in its alcoholism benefit plan for federal employees showed the the premium addition necessary to cover the cost of alcoholism treatment amounted to about 19 cents per beneficiary per month or some $2.30 a year. Neither the prevalence rate nor the costs of premium additions were different than those values derived in other studies.

-- Early treatment through comprehensive coverage for alcoholism can result in actual premium savings. This was demonstrated in a study newly released by the National Institute on Alcohol Abuse and Alcoholism. The study, involving the development of computer-based models to project costs and utilization of specific benefit packages for alcoholism treatment, showed actual premium savings of up to $6.22 annually as a result of alcoholism benefit packages, allowing for cost savings from reduced health care utilization and more appropriate diagnoses. Moreover, the more comprehensive plans not only showed the highest utilization and the lowest benefit payments, but the greatest premium savings.

-- Mandated alcoholism benefits are needed. In the last decade, a growing number of states have enacted laws in the area of health insurance for alcoholism treatment. Some require that such coverage be offered as optional; others have mandated alcoholism benefits in group health plans. Studies commissioned by the National Institute on Alcohol Abuse and Alcoholism of state legislative action have demonstrated that mandation is the only effective way to assure coverage -- that data from states with optional alcoholism benefits varies little from those where there is no statutory provision for alcoholism coverage.

It almost goes without saying that the adoption of a progressive health care policy in regard to alcoholism and drug abuse treatment and rehabilitation by the federal government would do much to alleviate the pain and suffering associated with unchecked and untreated alcoholism and drug abuse. The Hughes Act mandate to establish employee assistance programs in federal agencies provided an important service to federal employees by establishing a vehicle for the early identification and intervention for alcoholism and drug abuse problems. However, without access to adequate treatment and rehabilitation services, employees and EAP professionals are powerless to act.

In addition to concerns about the well-being and productivity of federal workers, the inclusion of adequate alcoholism and drug abuse rehabilitation benefits is clearly in keeping with any overall effort at health care cost containment. The financial burden of alcoholism and alcohol problems to the nation is now estimated to be about $120 billion annually, and may account for 15 percent of the nation's health care costs, according to the Congressional Office of Technology Assessment. An estimated 85 percent of those with alcohol problems are presently going without treatment.

According to the General Accounting Office, alcoholism may be costing the federal government as much as $694 million a year. GAO used NCA's estimate of 5.3 percent of the work force suffering from alcoholism and a 25 percent loss of productivity on the part of these workers, and applied these estimates to 2.8 million federal workers earning an average of $18,715. Again using NCA calculations, GAO projected that effective alcohol programs for the affected workers can result in a 50 percent gain in productivity -- and retrieval of $347 million.

The National Council on Alcoholism believes that the inclusion of alcoholism and drug abuse benefits in federal employees health benefits makes sense in human and fiscal terms. We have noted that one of the cost containment measures addressed in S. 2027 is the tying of the medicare prospective payment rates to rates payable under federal employees health insurance plans. We would direct your attention to the tremendous controversy that has arisen over the diagnosis related group for alcohol dependency as determined by the Health Care Financing Administration. Although we are hopeful that there will be some resolution of the problems regarding the alcoholism DRGs long before this legislation is enacted, we have included NCA's letter to HCFA on this matter for your further information.

Nevertheless, the cost containment provisions of S. 2027 including medicare diagnosis related groups and peer review mechanisms will continue to have little relevance to alcoholism and drug abuse treatment and rehabilitation as long as the legislation remains silent en these important and pervasive illnesses. Mr. Chairman, the National Council on Alcoholism hopes that you will seriously consider specifying alcoholism and drug abuse rehabilitation as a covered benefit for all federal employees health plans. Nothing short of statutory language spelling out alcoholism and drug addiction as covered illnesses will assure that federal employees suffering from these treatable diseases will have access to appropriate, cost-effective treatment.

RESOLUTION ON FEDERAL EMPLOYEE ALCOHOLISM BENEFITS

Whereas in 1982, benefits for the inpatient treatment of alcoholism were dropped from the largest health plan for federal workers -- the Blue Cross/Blue Shield plan, and

Whereas this action was taken by Blue Cross/Blue Shield and the Office of Personnel Management after the alcoholism treatment benefit had been in effect for only one year, and insufficient data had been obtained to justify the decision on an actuarial basis, and

Whereas NCA believes that the elimination of the alcoholism treatment benefit is counter to the Congressional mandate that appropriate treatment and rehabilitation be available to all federal workers, and

Whereas such action will result in increased costs to the government in terms of lessened productivity and higher health care expenditures for the consequences of untreated alcoholism not only for federal employees but their families,

Whereas, NCA applauds the leadership efforts of those in Congress seeking the reinstatement of such benefits,

Therefore, NCA strongly favors legislation and/or administrative action which would not only reinstate the Blue Cross/Blue Shield benefit for federal workers but mandate alcoholism treatment benefits be a part of all health plans offered to federal workers.

Adopted by the National Council on Alcoholism
Board of Directors; February 1983

National Council on Alcoholism inc. Public Policy Office

1100 17th STREET, N.W. • SUITE 710 • WASHINGTON, D.C. 20036 • (202) 223-1998

October 17, 1983

Carolyn Davis, Ph.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
Attention: BERC-263-IFC
Room 132, East High Rise Building
Baltimore, MD 21207

Dear Dr. Davis:

Attached you will find comments of the Board of Directors of the National Council on Alcoholism with regard to the Health Care Financing Administration Interim Final Rule for the Medicare Programs: Prospective Payments for Medicare Inpatient Hospital Services as described within the Federal Register dated September 1, 1983. Also included is a resolution adopted by the NCA Board of Directors regarding this rule at its October 15 meeting.

I hope you will find the insights of the National Council on Alcoholism helpful in your continuing deliberations on these important matters.

Sincerely,

Christine B. Lubinski

Christine B. Lubinski
Director
Public Policy Office

Enclosures

NCA, the only national voluntary health organization dedicated to combatting the disease of alcoholism.

National Council on Alcoholism inc. Public Policy Office

1100 17th STREET, N.W. • SUITE 710 • WASHINGTON, D.C. 20036 • (202) 223-1998

October 17, 1983

TO: Health Care Financing Administration

FR: National Council on Alcoholism

RE: Interim Final Rule for the Medicare Programs: Prospective Payments for Medicare Inpatient Hospital Services (BERC-263-IFC)

The National Council on Alcoholism is the nation's largest and oldest voluntary organization in the field of alcoholism. For four decades, NCA has worked to reduce the stigma attached to alcoholism, and to establish a recognition of alcoholism as a treatable disease and a major health problem. In addition to its basic purpose of educating the public about the nature of alcoholism, NCA plays a crucial role as the major advocate for the alcoholic at the national level.

From our perspective as an advocate for the suffering alcoholic, we would like to express our grave concern over the rules governing prospective payments for treatment under the "Alcohol Dependency" diagnosis related group (DRG). This new system as applied to alcoholism points up the need for overhauling the diseaee classification systems used by the Department of Health and Human Services as they relate to reimbursement for alcoholism services. The grouping of detoxification and rehabilitation services into one DRG with one rate of reimbursement and mean length of stay indicates a classification system out of touch with the state-of-the-art in the alcoholism field today. Separate DRGs should be established for detoxification and rehabilitation.

While there appears to be a strong consensus of opinion in the alcoholism field regarding the clear delineation between detoxification and treatment services, there is no unanimity about the optimum placement or length of stay for alcoholism treatment. In fact, the Senate Appropriations Committee Report on FY 84 Labor-HHS-Education Appropriations bill echoed the conclusions of the March, 1983 Office of Technology Assessment on the effectiveness and costs of alcoholism treatment. That study states unequivocally that efforts to improve the current body of knowledge governing patient placement in regard to appropriate alcoholism treatment and setting are warranted. The Senate Appropriations Committee has acted on the OTA's study's conclusions by directing the Department of Health and Human Services to report to the Committee by March 31, 1984, "on steps being taken to support research leading to the development of a standardized patient placement system to match alcoholics with the appropriate level of care responding to the stage and/or severity of the disease upon diagnosis and admission." The OTA study and the Congressional action coupled with the varying perspectives on treatment assessment and placement by researchers and clinicians in the alcoholism field would all seem to suggest that a standardized system such as that represented by the alcohol dependency DRG is premature in this field. Finally, the groundbreaking work under way in the form of the 4-year HCFA study of the feasibility of Medicare reimbursement of alcoholism treatment services in non-hospital freestanding treatment facilities gives us further cause to urge HCFA to delay the implementation of what appears to be an arbitrary and premature standard for reimbursement of alcoholism services.

NCA urges that alcoholism units be granted specific exemptions from the prospective payment system on a limited basis as accorded psychiatric units under the new plan. The Council has grave reservations over the requirement that alcoholism units, in order to be exempt, must meet the criteria for exempted psychiatric units. The requirement raises the danger that traditional alcoholism programs might convert to inappropriate psychiatric models to achieve exemption from the new Medicare reimbursement system -- a development we would deplore.

In the process of developing the needed revisions, we urge the Health Care Financing Administration to collaborate closely with the National Institute on Alcohol Abuse and Alcoholism, the Alcohol, Drug Abuse and Mental Health Administration, and the alcoholism community. The National Council on Alcoholism recognizes the urgent mission of HCFA to implement cost-effective reforms of the Medicare system. Nevertheless, cost-savings strategies which jeopardize accessibility to treatment and rehabilitation to the suffering alcoholic are not only morally inappropriate, but will ultimately impede serious progress toward fiscal health for the Medicare system. The Board of Directors of the National Council on Alcoholism and its Public Policy Committee members stand ready to assit you in dealing with these issues.

RESOLUTION ON PROPOSED RULE FOR PROSPECTIVE PAYMENT REIMBURSEMENT FOR MEDICARE INPATIENT SERVICES FOR ALCOHOLISM TREATMENT

Whereas, the proposed alcohol dependency diagnosis related group (DRG) couples detoxification and treatment services with a mean length of stay which appears based upon a data base which reflects only partial treatment, and

Whereas, more research is needed on appropriate standards in terms of setting or length of stay for alcoholism treatment, and

Whereas, Congress has directed the Department of Health and Human Services to report back on its efforts to encourage research leading to the development of a standardized patient placement system for alcoholism treatment, and

Whereas, the Health Care Financing Administration is presently conducting a 4-year study of feasibility of Medicare reimbursement of alcoholism treatment services in non-hospital freestanding treatment facilities as a vehicle for fiscal reform, and

Whereas, the Health Care Financing Administration has set a precedent for granting limited exemptions for other medical classifications where precise data on the nature and length of treatment is unavailable,

Therefore, the National Council on Alcoholism urges the Health Care Financing Administration to exempt alcoholism treatment services from application of the proposed system for prospective payment for Medicare reimbursement until an appropriate data base is available.

The National Association of Private Psychiatric Hospitals

1319 F Street, NW □ Suite 1000
Washington, DC 20004 □ 202-393-6700

Statement Of

MARTIN H. STEIN, M.D.

for the

National Association of Private

Psychiatric Hospitals

on S. 2027

Before the Subcommittee on Civil Service,

Post Office, and General Services

Senate Governmental Affairs Committee

December 1, 1983

Mr. Chairman and members of the Subcommittee:

I am Martin H. Stein, a psychiatrist. I am Medical Director of the Dominion Psychiatric Treatment Center in Falls Church, Virginia. I appreciate the opportunity to appear today on behalf of the National Association of Private Psychiatric Hospitals (NAPPH), to comment upon S. 2027, the legislation you have introduced to reform the Federal Employees' Health Benefits Program (FEHBP). The NAPPH represents the nation's freestanding, nongovernmental, psychiatric hospitals comprising some 23,000 beds. These hospitals provide for the medical care and treatment of persons of all ages suffering from various forms of psychiatric illness.

Mr. Chairman, because of the time limitation, I will summarize my remarks here and ask permission to submit the prepared written statement for the record.

The NAPPH appreciates your interest in the need for certain improvements in the administration and financing of the FEHB program. While your legislation addresses a number of the problems that have bedeviled the FEHB program during the past three years, the NAPPH does have specific concerns dealing with the definition of "catastrophic coverage" in S. 2027 and the absence of a mandated minimum level of mental illness, alcoholism, and drug abuse benefits.

The catastrophic coverage language as now written in S. 2027 is unclear and confusing in terms of intent. Does the $3,000 limit on out-of-pocket expenses for an individual apply only to a single illness or injury in a given year? Would this limit be applied separately to each illness or injury that is not related to each other? Might an individual thus be subjected to out-of-pocket expenses far in excess of the $3,000 limit because each illness would be treated differently in terms of triggering catastrophic coverage?

If the answer to all of these questions is "yes," then the catastrophic language runs contrary to established insurance principles limiting out-of-pocket expenditures for individuals who have incurred an illness of a catastrophic nature and belies the bill's intent.

Since the legislative intent of S. 2027 accepts the notion of catastrophic coverage, we urge that the language in Section 202 be redrafted to communicate clearly the definition and meaning of catastrophic coverage. If the $3,000 per individual and $6,000 per family limits are used, then the catastrophic coverage should be defined to cover all unrelated illnesses or injuries in a given year up to the specified threshold, at which time the plan would then pay 100 percent of catastrophic expenses. To define and apply catastrophic coverage in this way would be to conform the legislative intent and language of S. 2027 to the prevailing principles of insurance protection for individuals and families faced with catastrophic-type expenses.

Our second point of concern deals with the absence in S. 2027 of a standard, mandated level of benefits covering treatment for mental illness, alcoholism, and drug abuse. A close reading of S. 2027 suggests that FEHB plans would be allowed, within the existing statutory framework, to design benefit packages largely at their own discretion in terms of the kinds and levels of benefits offered to employees. A carrier or plan could then theoretically offer a very attractive benefit in one area--say, comprehensive dental coverage--while minimizing benefits in another area--say, mental illness coverage. With such latitude and discretion, carriers would have no incentive and would not be under any clear administrative or legislative obligation to offer benefits in a nondiscriminatory manner. As the experience of the past three years too vividly demonstrates, when there is no statutory mandate for a carrier to offer a minimum level of specific benefits, the one area that will be cut is coverage for treatment of mental illness, alcoholism, and drug abuse.

For this reason and others, the NAPPH feels very strongly that all FEHB plans must offer a mandated minimum level of mental illness, alcoholism, and drug abuse benefits, using the minimum as a base, not as a ceiling. The NAPPH strongly urges you to consider the inclusion of language in S. 2027 that would require FEHB carriers to provide a specific minimum level of mental illness, alcoholism, and drug abuse benefits. The language mandating this kind of coverage could be comparable to that already in Section 5 of H.R. 656, the FEHBP reform legislation introduced in the House by Congresswoman Mary Rose Oakar, Chairwoman of the Subcommitee on Compensation and Employee Benefits. Cosponsored by 117 members of the House, H.R. 656 mandates 60 inpatient days and 50 outpatient visits per year for psychiatric care and two 28-day alcoholism rehabilitation periods per lifetime.

The recent history of the FEHBP is replete with evidence of the susceptibility of mental illness benefits to the political and budgetary whims of the Office of Personnel Management (OPM). It is merely a statement of fact that OPM has methodically singled out one category of health benefits for disproportionate and discriminatory cuts--mental illness, alcoholism, and drug abuse. For example, in 1980, Blue Cross/Blue Shield provided 365 days per year of inpatient psychiatric care as well as an unlimited number of visits for outpatient care at 70 percent coverage under the High Option. In 1982, in response to OPM's directive to carriers to cut benefits an average of 13 percent, Blue Cross/Blue Shield reduced inpatient psychiatric care from 365 to 60 days per year and limited outpatient visits to 50 days a year with 50 percent copayment. In addition, the alcoholism benefit was dropped altogether.

OPM's decision in July of this past year to require FEHB plans to offer a so-called "catastrophic" mental health benefit for 1984 at no additional cost to the premium will, ironically, tend to make it more difficult for desperately ill patients to receive the kind of care and treatment their psychiatric disability requires. To continue to treat mental illness differently from, and more expensively than, various kinds of physical illness, encourages precisely the kinds of discriminatory cuts we have witnessed in mental health benefits during the past three years. Mr. Chairman, the unfortunate fact is that FEHB plans in 1984 will offer more severely limited and/or reduced psychiatric, alcoholism, and drug abuse benefits at considerable out-of-pocket expense for the beneficiary in terms of higher deductibles and copayments. For example, the most generous catastrophic coverage benefit offered in 1984 will apply only after an individual has incurred $4,000 in out-of-pocket expenses for a psychiatric illness on a per annum basis.

In addition, the NAPPH would like to express its support of legislation that provides for peer review to authorize payment for catastrophic expenses that are medically or psychologically necessary, to be funded by a shared risk pool consisting of contributions from all of the carriers in the FEHB program. In this regard, we feel that the peer review mechanism as envisioned by both H.R. 656 and S. 2027 should function to approve only medically or psychologically necessary care on a case-by-case basis concerning coverage of catastrophic expenses, thus assuring against overutilization, which in turn would hold down costs.

Mr. Chairman, the NAPPH appreciates your interest in this matter and wishes to work with you closely in making the reforms that are needed in the FEHBP.

AAP ASSOCIATION for the ADVANCEMENT of PSYCHOLOGY

STATEMENT OF

CLARENCE J. MARTIN

Executive Director and General Counsel

Association for the Advancement of Psychology

on behalf of

THE AMERICAN PSYCHOLOGICAL ASSOCIATION

and

THE ASSOCIATION FOR THE ADVANCEMENT OF PSYCHOLOGY

before the

Subcommittee on Civil Service, Post Office and General Services

Senate Committee on Governmental Affairs

regarding

S. 2027 "THE FEDERAL EMPLOYEES HEALTH

INSURANCE AMENDMENTS OF 1983"

AND RELATED PROPOSALS

December 1, 1983

Senator Ted Stevens, Chairman

Mr. Chairman:

My name is Clarence Martin and I am the Executive Director and General Counsel of the Association for the Advancement of Psychology. I am representing the over 72,000 psychologists who are members of the American Psychological Association and of AAP. I appreciate the opportunity to appear before you and testify on S. 2027, S. 1685, and H. R. 3798.

The need to reform the Federal Employees Health Benefit Act has been well documented by Congress itself. Three recent reviews, initiated by Congress, have produced remarkably similar conclusions.

The Mercer Report (Review of the Federal Employees Health Benefits Program, U.S. House of Representatives, Committee on Post Office and Civil Service, 97th Congress, 2nd Session, Committee Print 97-8, 7/13/82), the General Accounting Office Report requested by Senator Stevens, (Financial and Other Problems Facing the Federal Employees Health Insurance Program, GAO/HRD-83-21, 2/28/83), and the study of the Congressional Budget Office (Adjustments in Federal White Collar Pay, Committee Print 98-4 Committee on Post Office, Civil Service, 3/22/83) all concur that FEHB plans do not favorably compare to health insurance provided in the private sector in either their level of benefits or limits on employee cost. The studies go on to recognize that FEHB plans are regressively falling behind coverage provided in the private sector.

One further issue recognized in all three of these studies, and the one on which I wish to focus, is that mental health, alcohol and drug abuse coverage in FEHB is inferior to the coverage provided in the private sector.

I would like to take this opportunity to thank the Chairman and his staff for the diligence and hard work they have expended in seeking to assure federal employees and annuitants of health insurance benefits that are comparable to those of the private sector. Speaking for myself and those organizations which I represent today, let me especially express our appreciation for your support for equal treatment in the provision of mental health benefits. In introducing S. 2027 before the Senate on October 28, 1983, Senator Stevens presented six broad issues addressed by his bill. I would like to review those six issues briefly from the position of American psychology.

First, Title I of S. 2027 allows a health benefit plan carrier to offer one Medicare supplemental plan for Medicare-eligible annuitants to provide benefits such as drugs and mental health care, which are not provided by Medicare.

This is a much needed reform and should be welcomed by the entire mental health community. The outpatient Medicare benefit, which has not been updated since the inception of the program, provides for a maximum $250 Medicare expenditure per annum, requires a fifty-fifty co-payment and excludes access by the patient to all but a few practitioners. It encourages the use of far more expensive inpatient services and denies our elderly population a service of which they are particularly in need.

The benefit allowed in Title I could well serve as a model for the whole insurance industry.

Second, S. 2027 requires that all plans carry reasonable deductibles and co-payments. We understand this provision is intended to establish a requirement which will encourage plans to compete economically by using the co-payment and deductible mechanisms to assure consumer sensitivity to costs while discouraging, through the "reasonable" requirement, the offering of token or moot benefits by the plans. We believe this provision needs to be clarified. It may help to add to the amendment 8902 (n)(1) after the word "reasonable" the phrase "and non-discriminatory".

Historically it has been the discrimination in health insurance towards mental health, alcohol and drug abuse coverage that has led both the providers and consumers of these services to seek fixed benefits and guarantees of minimum levels of coverage. The Associations I represent today would prefer such detailed assurances. Lacking mandated parameters of coverage it becomes extremely important that a clear and unequivocal policy of nondiscrimination between mental and physical health treatment be enunciated.

Third, we believe that the provisions of Sec. 202 which mandate inpatient and outpatient benefits for care and treatment of mental disorders will provide an important improvement in the FEHB program.

Over the past several decades, research has consistently shown the close connection between mental health and physical well being. Studies have demonstrated that proper treatments for mental disorders, alcoholism, and drug abuse have improved worker productivity, have reduced absenteeism and accidents in the workplace, and have reduced dependence on more costly medical treatment. Further, the costs involved have been reasonable. For example, since 1975, only 2% of FEHB enrollees have used these benefits, representing less than 8% of total costs.

Over the last decade, many of America's largest corporations have instituted programs to provide care for employees who suffer from alcoholism, drug abuse, and mental disability. Companies such as IMB, General Mills, and the 3M Company include these benefits as part of their employee's basic health care package. Industry has recognized the economic and human resource returns achieved by such programs in many areas. Let me share some of them in more detail.

INCREASED PRODUCTIVITY: A 1980 survey by the Washington Business Group on Health shows that 68 out of 100 major corporations had programs providing services for their employees' mental health, alcoholism, substance abuse, or stress problems. The result: an increase in employee productivity. According to Dr. William Mayer, former Administrator of the Alcohol, Drug Abuse, and Mental Heath Administration, companies are finding an 8 dollar return for each 1 dollar invested in employer sponsored programs for on-site treatment, intervention, and education regarding health care needs.

REDUCED ABSENTEEISM: The same survey found that mental and nervous disorders underlie 6 out of 10 absences. Yet, independent studies at corporations show remarkable changes in absenteeism when mental health and substance abuse benefits are properly used: a 55% decrease in absenteeism following mental health intervention at Illinois Bell Telephone in Chciago; and a savings of $233,000 through a reduction in lost work hours at a Michigan Oldsmobile plant following a drug and alcohol rehabilitation program.

REDUCED INURIES, ACCIDENT AND DISABILITY CLAIMS: The same Michigan Oldsmobile plant study found up to 40% of industrial fatalities and 47% of industrial injuries can be linked to alcohol abuse. Another study at a major corporation indicates that mental and emotional problems underlie 8 out of 10 industrial accidents. After initiating an Employee Assistance Program that included alcoholism treatment, the Firestone Company reported a 65 percent reduction in the use of accident and sickness benefits, and a 48 percent reduction in the use of hospital, surgical, and medical benefits.

REDUCED USE OF OTHER MEDICAL SERVICE: Mental health, alcoholism and substance abuse treatments reduce dependence on medical care. This finding has been documented time and again in studies throughout the United States and Europe. In their major review of the literature, Jones and Vischi found an average reduction in medical care use of 20 percent following mental health treatment and an average reduction of 40 percent following alcohol abuse treatment. Note that these figures are averages. In some cases, the reductions were much higher.

In 1979, the city of Redondo Beach, California contracted for outpatient mental health services as part of their group medical plan. From 1979 to

1981, this service was used by 6 to 8% of plan enrollees. During this period, costs were so low that preimums remained stable and a $200,000 budget savings occured. Furthermore, absenteeism due to sickness dropped by almost 50%.

Inspite of this strong evidence pointing to the usefulness of mental health benefits, these are exactly the benefits that suffered disproportionately under OPM's reductions in 1982.

A second, but no less important service is performed by mandating these benefits. The problem of adverse selection has plagued plans offering attractive mental health, drug abuse and alcoholic benefits, and this adverse selection will only be overcome by mandated benefits. Without mandating mental health benefits, OPM guarantees the very adverse selection they protest -- persons needing particular services will continue to subscribe to plans that cover them most generously and costs will continue to rise. The voucher system proposed by H. R. 3798 and the limited access proposal of S. 1685 would perpetuate this same behavior. No assurances exist for any kind of minimum benefits, and no incentive is provided to offer bnefits for the treatment of mental disorders and substance abuse. The system would continue to promote adverse selection by allowing the discriminatory offering of selected benefits. No mandate of this sort exists for physical health care because such limits as exist are reasonable and equitable -- not so for mental health benefits. The Mercer report stated clearly that standardized benefits are a <u>solution</u> to the adverse selection problem.

I would go even further in predicting, upon the passage of this bill, greater competition and lower costs among mental health practitioners. States with mandated mental health benefits show nine percent lower practitioner costs than states without such mandates. Competition would be enchanced by assuring minimal levels of coverage such as proposed by S. 2027; enrollees would no longer adversely select a plan simply because it offered mental health benefits. Market forces would operate such that plans wuld have to fine-tune their benefit and premium levels to respond to enrollees total health care needs -- this is competition at its best.

Fourth, we applaude the inclusion in S. 2027 of a catastrophic benefit which would assure that any out-of-pocket expenses for health care by the employee due to an illness or injury covered under the plan could not exceed $3,000 per person or $6,000 per family. It is our understanding that these figures are intended only as maximum out-of-pocket costs. Any carrier could offer catastrophic protection with a lower trigger amount than those provided by the act.

We read Sec. 202 to say that the maximum amounts ($3,000 per individual and $6,000 per family) represent accumulated out-of-pocket expenses from all illnesses or injuries covered within a policy year -- after which the catastrophic coverage would be triggered and would cover all illness or injury for the remainder of the policy year. There is some ambiguity in the language of the bill but I hope that we can clarify that today and our interpretation would be acceptable.

Fifth, we understand that S. 2027 provides for a change in the way the government's contribution to FEHB is calculated. Instead of the government's contribution being based upon the average of the big six premiums, the government's contribution will be 70 percent of the weighted average of all premiums. The assumption being that this new formula will reduce the employee contribution to the plans.

We would appreciate and find useful a summary of the actuarial base and assumptions used in calculating the differences between the present and proposed system. We now do not have access to the statistical base that would be necessary for us to provide appropriate comments.

Sixth, we would like to ask permission of the Chair to extend our comments on several aspects of the proposed comprehensive cost containment program and the strategies and procedures which implement them.

We are concerned that the system for peer review of the utilization and quality of health care set out in Sec. 204 (b)(1) may not be best served by using Title XI of the Social Security Act as a model. There are alternatives including those developed by the American Psychological Association and the American Psychiatric Association which may be more realistic systems for achieving the objectives spelled out in the bill. Further, based on a number of years of experience with peer review, the American Psychological Association is now engaged in an effort that will additionally improve its own program for quality assurance. We hope to have an opportunity to discuss this in more detail with your staff in the near future.

OTHER LEGISLATION

We would like to say a few words about several other bills presently pending in the House and Senate on this subject.

H. R. 3798

On August 4, 1983 Mr. Dannemeyer (R-Calif.) introduced, by request of the administration, H. R. 3798. This bill would take a voucher approach in providing health insurance for federal employees. It would permit any legal entity licensed to market group health insurance to participate as long as the entity meets minimum requirements established by OPM. OPM would review plans but would not contract for those plans. Employees could make a choice from any plan marketed in their geographical area using their voucher to make all or part of the premium payment.

We believe that the voucher approach would constitute an abdication of the government's responsibility as an employer to insure that adequate benefits are provided, that federal employees are being offered actuarially and fiscally sound plans, and that the full advantages of the fundamental principles of group insurance and shared costs aare maintained. In his remarks introducing the bill Mr. Dannemeyer raised questions about the bill which we share, including questions concerning; abusive marketing practices by new carriers, rights of annuitants, how to treat preexisting medical conditions, the issue of at least one standard package to facilitate comparison, etc.

The voucher system offers too mamy questions and too few answers and we cannot support it.

S. 1685

On July 27, 1983 Senator Durrenburger (R-Minn.) introduced S. 1685 which would provide a base benefit defined as at least as comprehensive as the low option AEtna plan offered in 1983.

Beyond this minimum benefit, plans may offer whatever additional benefits they believe marketable. In order to avoid adverse selection the federal government will adjust its contribution to each federal employee for each health plan based on the relative risk of enrollees including such factors as age, sex, place of residence, and job status. Both active employees and annuitants will pay the same amount out-of-pocket for joining the same health plan. Only the government's contribution will vary.

The problem that S. 1685 does not address is that utilization is not determined only by age, sex, location, and job status. Young and old, male and female, urban and rural, employed or retired, federal employees are susceptible to mental and physical illnesses which require a specialized benefit which must be available beyond those provided by the low option indemnity plan. Some plans will attract those seeking specific coverage and the problem of adverse selection will be compounded not alleviated. We do not believe S. 1685 is a viable proposal.

H. R. 656 and S. 1004

We urge this committee to review carefully the provisions of S. 1004 (D'Amato, R-NY) and Title V of H. R. 656 (Oakar, D-Ohio). These bills mandate a standardized benefit for mental health and substance abuse treatment, provide catastrophic coverage for mental disability (funded though a shared risk pool), and they rely on peer review to determine that reimbursement is only for mediclally or psychologically necessary treatment.

Under these bills, all benefits must be offered in a non-discriminatory manner -- the coinsurance ratio and the deductible amounts must be the same for mental health as they are for physical health benefits. For the nervous and mental disorder benefits, 50 outpatient vists and 60 inpatient days would be covered on an annual basis, by all government-wide plans. Additionally, two 28-day alcoholism or substance abuse treatment and rehabilitation benefits must be provided as a lifetime benefit. This level of benefits is more consistent with private sector coverage and is sufficient for the majority of persons with mental disroders as well as those who have alcoholism or substance abuse problems.

H. R. 656 and S. 1004 provide a catastrophic mental health benefit as well. Catastrophic coverage would be triggered only after an established peer review mechanism determines such treatment to be "medically or psychologically necessary and appropriate". This ensures that federal workers, their families and annuitants who are truly in need of catastrophic care will receive necessary treatment. The mechanism for financing catastrophic benefits would be through a shared-risk pool, establisled from the existing Administrative Expense Fund to pay for mental health treatment exceeding the standard benefit level. These provisions would guarantee that no health benefit plan would be adversely affected by having a disproportionate share of enrollees receiving catastrophic mental health care.

In conclusion:

- We support Title I of S. 2027 as a positive and constructive response to the inadequacies of Medicare coverage of mental health services.

- We urge a more specific definition of the requirements under Sec. 8902 (n)(1) of what constitutes "reasonable" benefits.

- We support the provisions of Sec. 202 which mandate inpatient and outpatient benefits for mental disorders.

- We reject H. R. 3798 as a proposal which offers more questions than answers.

- We reject S. 1685 as a bill which would not alleviate but compound the problem of adverse selection and would promote increased government intrusion into health care benefits.

- We support the inclusion of a catastrophic benefit in the FEHBA.

- We support an increase in the federal employer's share of the FEHB premium.

- We believe that a careful examination of the proposed comprehensive cost containment program and the strategies and procedures which implement them should be undertaken.

Thank you for this opportunity to testify.

Statement by Andrew P. Miller

on Behalf of the National Federation of
Societies for Clinical Social Work, Inc.

on S. 2027

Before the Subcommittee on Civil Service,
Post Office and General Services
of the
Senate Committee on Governmental Affairs

The Honorable Ted Stevens, Chairman

December 1, 1983

2101 L Street, N. W.
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Mr. Chairman and members of the Subcommittee, my name is Andrew P. Miller. I am here to present the views of the National Federation of Societies for Clinical Social Work, Inc., with respect to proposed amendments to the Federal Employee Health Benefits Act (FEHBA). Specifically, I wish to focus my remarks on those provisions of S. 2027 which relate directly to the provision of coverage for mental illness. I will also make reference to other bills pending in the Congress which deal with the same issue. I would like first, however, to review the context in which this legislation is being considered.

On January 1, 1982, discriminatory cutbacks by the Office of Personnel Management led to the elimination of the alcoholism treatment benefit and a drastic reduction in mental health benefits provided under the Blue Cross/Blue Shield Plan, which then covered approximately 60 percent of Federal Employee Health Benefits Program (FEHBP) beneficiaries.

This reduction in coverage came despite studies which demonstrate convincingly that proper treatment for mental illness, alcoholism and drug abuse is not only cost effective but improves work productivity and reduces absenteeism in the workplace.

For example, the President's Commission on Mental Health concluded that "research from industrial programs, health maintenance organizations (HMOs) and from regular health insurance plans suggests that providing outpatient mental health services can reduce overall health services utilization and overall health costs. The evidence strongly suggests that the cost of including or expanding mental health coverage would be partially or wholly offset by decreasing use of general medical services."[1]

The Commission also determined that as many as 60 percent or more of physician visits are by sufferers of emotional distress rather than diagnosable organic illness.[2]

The HEW Task Force which reviewed the report of the President's Commission similarly took note of the decreased cost of physical health services which could be expected to flow from increased utilization of mental health services.[3]

An article published by Jones and Vischi, of the Alcohol, Drug Abuse and Mental Health Administration, summarized the results of twelve separate studies which have demonstrated that the cost of providing mental health services was offset by a significant decline in medical utilization.[4]

Messrs. Carr and Sharfstein, in an article authored at the National Institute of Mental Health, demonstrated with appropriate data that there is simply no truth to the notions that 1) utilization and cost of treatment for mental illness are unpredictable, (2) psychiatric illness is chronic, (3) psychiatric outpatient treatment is slow and often requires years, (4) psychiatric treatment is of doubtful effectiveness, and (5) there is no agreement on diagnosis or appropriate treatment for psychiatric problems.[5]

In 1980, the Washington Business Group on Health (WBGH) surveyed 100 major corporations and found that 68 provided services for their employees affected by mental illness, alcoholism and/or substance abuse. Most of such companies reported an increase in employee productivity as a direct benefit. In addition, Dr. William Mayer, the current Administrator of the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) has concluded that "many companies are finding an $8.00 return for each $1.00 invested in an Employee Assistance Program," of the type referred to by WBGH.

As to reduced absenteeism, again the WBGH survey found that 6 out of 10 absenteeisms are caused by mental illness. The survey stated that the Illinois Bell Telephone Company in Chicago showed a 55% decrease in absenteeism with the help of an Employee Assistance Program, and that a Michigan Oldsmobile plant saved $233,000 through a reduction in lost man-hours after establishing an industrial drug and alcohol rehabilitation program.[(6)]

Thus, it is clear that the cost of leaving mental health needs unattended are enormous both in human and social terms. The Federation wishes to commend you, Mr. Chairman, for your recognition of this fact in Section 202(a) of S. 2027. This section mandates the provision of "inpatient and outpatient benefits for care and treatment of mental disorders" in plans offered pursuant to FEHBP. Similar provisions are found both in S. 1004 introduced at this Session by Senator D'Amato and in H.R. 656 introduced by Representative Oakar.

Historically, a number of FEHBP plans have provided either no or very inadequate mental health benefits. To the extent this reticence results from a perception that the cost of treatment for mental illness cannot be quantified, it is unfounded. Over an eight year span leading up to 1982, for example, the mental health coverage provided through Blue Cross/Blue Shield amounted to a constant 7.0 to 7.5% of the benefits paid.

The real obstacle to the provision of appropriate coverage for mental illness has been "adverse selection". The few plans which have offered anything like adequate benefits found themselves subscribed by a very high percentage of those federal employees who needed care for and treatment of mental disorders. Other plans which did not provide comparable benefits did not incur this type of cost. For this reason, since persons with mental illness constitute a minority of federal employees, there was no effective competition among FEHBP plans in the offering of coverage for such disorders.

While representing a step forward, the present language of Section 202(a) does not solve the problem of adverse selection. It should, therefore, be revised in markup to prohibit discrimination in the provision of mental health services compared with other inpatient/outpatient services as to the level of indemnity, the ratio of coinsurance and the amount of deductible. This principle of non-discrimination is currently embodied in both S. 1004 and H.R. 656. Such a provision would not require a plan to be "high option", "standard" or "low option". It would simply mean that, whatever the indemnity level, the coinsurance ratio or the deductible amount established by a plan, it would be equally applicable to mental illness as to other illnesses. The unconscionable discrepancy existing in some FEHBP plans between mental health services and other inpatient/outpatient services would thereby be eliminated.

Another advantage of requiring nondiscrimination is that it would provide meaning to the mandate of Section 201(n)(1) that "each health benefits plan offered under this chapter shall provide reasonable deductibles and coinsurance for all benefits under the plan." Obviously, what is "reasonable" in the context of deductibles and coinsurance is a matter of wide divergence of opinion. Unless the term "reasonable" is given some objective definition, the Federation anticipates substantial dispute, if not litigation, over its meaning. If, however, there is nondiscrimination in such areas as between mental health services and other inpatient/outpatient services, as a practical matter any such controversy would be eliminated.

The Federation also wishes to commend you, Mr. Chairman, for the inclusion in Section 202(b) of a requirement for catastrophic coverage. It is our understanding that this provision on an individual basis relates to any single injury or illness with respect to which charges for care and treatment during any contract year exceed $3,000. It is our further understanding that, even if the charges for any one injury or illness do not reach $3,000 per year, catastrophic coverage is to be provided when all charges for care and treatment exceed $6,000 per individual or family during any contract year. The Federation further understands that no maximum could be imposed by any plan in the furnishing of catastrophic coverage with respect to any such contract year. Section 202(b) represents a long overdue reaction to the reality that, without provision for catastrophic coverage, some federal employees and their families with serious illness are each year confronted with financial disaster. We, therefore, endorse the provisions of Section 202(b) in principle.

Before concluding, I would like to make brief reference to H.R. 3798 introduced this session by Representative Dannemeyer. This proposal for amending FEHBA would utilize a voucher approach in providing health insurance for federal employees. It contemplates a procedure whereby OPM reviews certain features of plans but does not contract for those plans.

The Federation concludes that there are major problems with this concept and, therefore, strongly opposes its adoption. Specifically, it would magnify rather than reduce the problem of "adverse selection". Younger, healthier employees would select the low cost, low option plans leaving older, higher risk employees to whatever high option, high cost plans remained. The proposal, if implemented, would undermine the fundamental principle of group insurance and shared cost.

The course taken by H.R. 3798 also constitutes an abdication of the government's responsibility as an employer to insure that adequate benefits are provided. Should OPM withdraw from negotiations for discrete coverages, it is probable that currently available benefits for mental illness would be even further curtailed. The predictable result is that essential protection would become either unavailable or prohibitively expensive.

For the foregoing reasons, Mr. Chairman, the Federation submits that the concept of amending FEHBA to require mental health coverage and catastrophic benefits in all FEHBP plans is sound. The Federation further believes that the principle of nondiscrimination as to indemnity level, coinsurance ratio and deductible amount as between mental health services and other inpatient/outpatient services should be adopted. Finally, the Federation urges that the approach embodied in H.R. 3798 be rejected.

References

1. The President's Commission on Mental Health, Report to the President, "Report of the Task Panel on Cost and Financing," Vol. II, p. 513.

2. Id., "Report of the Task Panel on Mental Health of the Elderly," Vol. III, p. 1128.

3. GLS Associates, Inc., Report to National Institute of Mental Health, "Analysis of State Programs Which Mandate Mental Health Under Private Health Insurance," June 29, 1979, p. 68.

4. U.S. Department of Health, Education and Welfare, Alcohol, Drug Abuse and Mental Health Administration, Impact of Alcohol, Drug Abuse and Mental Health Treatment on Medical Care Utilization, by Kenneth R. Jones and Thomas R. Vischi, reprinted in Medical Care, Vol. XVII, No. 12, Supplement.

5. Reprinted in Washington Business Group on Health, Mental Wellness Programs for Employees, 1980, pp. 154-5.

6. Washingon Business Group on Health, Mental Wellness Programs for Employees, 1980.